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**Remnants of Humanity:**

**Psychiatry and Post-Socialism in the Czech Republic**

**1989-2010**

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**Ph.D. in Social Anthropology**

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## **Abstract**

### **Remnants of Humanity: Psychiatry and Post-Socialism in the Czech Republic 1989-2010**

This thesis explores the roles that medicine, human rights discourse, and the arts play in the project to improve the lives of patients suffering from severe forms of mental illness in the context of the post-socialist transformation of the Czech Republic. It is a study of the ways in which social solidarity and social exclusion intersect in the spaces of mental illness in a particular historical setting, and how the responsibility for care is negotiated between families, communities, the medical profession, and the state.

The first part of the thesis focuses on the proposed reform of care for patients with severe mental illness that was put forward in the two decades after 1989. I examine the origins and aims of the attempted institutional change – the ‘humanization of psychiatry’ – in the context of the influential Charter 77 movement which demanded respect for the rights of those who are unable to claim them for themselves. I also trace how the re-establishment of a civil society that owed much to the concept of ‘apolitical politics’ and the process of the reintegration of Czech Republic into the European community impacted the attempted reforms. More than twenty years after the revolution, Czech Psychiatry still does not comply with international standards of care and, as I show, despite the explicit disclaimer with the totalitarian past and great hopes for change, there is in fact a clear continuation of many of the practices, ideas, interactions, as well as forms of governance of the preceding decades. These historical legacies, in combination with other factors, such as ideological disagreements within the psychiatric profession, a lack of political interest in this area, and a strong focus on other economic priorities have all contributed to the failure to improve mental health care.

The second part of the thesis offers a complementary perspective on these processes – a view from ‘inside’ of the institutions that provide psychiatric care. The origins of institutional care in Central Europe date back to late nineteenth century,

when large hospitals were built within parks as self-sufficient complexes surrounded by walls, outside of large cities. My research took place in two contrasting institutions: one a highly specialised clinical and research center for treatment of acute conditions, and the other a hospital for treatment of chronic conditions originally devoted to those with ‘incurable’ conditions. I show how the notion of ‘curability’ is a crucial factor in both the experience of the patients and the social responses to their conditions. In this part I also explore some epistemological issues in psychiatry, including knowledge, practices, and ideology, in the context of a strong scientific materialism where – unlike in many parts of the world – the tradition of psychoanalysis has been absent. Specifically, I examine the role of neurobiological paradigm in various interpretations of psychotic experience, its affect on patient’s self-understanding, and its role in the externalization of agency and responsibility. Finally I address the phenomenon of using ‘unclaimed bodies’ of psychiatric patients for anatomical teaching and research, and interpret this practice through notions of liminality, impurity, and sacrifice.

I conclude the thesis by examining the ethical dimension of psychiatric care in the light of the writings by Emmanuel Lévinas.

## **Declaration**

I hereby declare that this thesis has been composed entirely by me and is my own work.

No part of this thesis has been submitted for any other degree or professional qualification.

Lydie Fialová

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And finally and above all, to my family.

*To my parents –  
my mother Rut,  
my father Bohuslav, in memoriam.*



## **INTRODUCTION**

## Waiting for Healing



Kosmonosy hospital 2007

One day on my way back to the Kosmonosy psychiatric hospital from lunch down in the village I realized that the doors of the church were open. As part of the

hospital complex the beautiful Baroque church was always closed. Although the white paper on the doors indicated that the church is open exclusively on Sunday at 11 for the Mass – and on which ‘PLEASE DO NOT STEAL THIS PAPER!’ was written in large letters – was still there, nevertheless, the warm sunshine found its way through the open doors and shadowy space to illuminate the altar at the far end of the church. The sculptures by a local family workshop whose fame reached beyond the borders of the Province were silent, watching the time passing by. The darksome atmosphere of a rarely visited place filled the space and demanded one to move as inaudibly as possible not to disturb the silence and solemnity of the space. This silence was suddenly interrupted by a sharp male voice: “One, two, three, one, two three” – three steps towards the other microphone, and again, “one, two, three, one, two – what are you doing here?!!!” By this rather harshly posed question I was brought back to the present and shyly answered – well, I just saw the doors open and thought that possibly I might... – only to realize that actually I was not the one being asked. I was not the only one who dared to enter this place despite the paper on the doors. There was another woman, and soon I realized I saw her earlier that day on the ward round – Aneta – and she, unprotected by the white medical coat as I was, was the one addressed by this man.

“Well, I just came..., well..., I am... I am looking for the help of God... Here... I thought He might...”

“Have you not seen the paper on the door?? You need to come on Sunday at 11 if you are looking for that! Not now, it is closed to public, don’t you see?”

“Yes..., but I thought... I am allowed to leave the ward only in afternoons so I can not come on Sunday at 11, you know?”

“Well, I do not know about your schedule but – to be honest – none was ever helped in Kosmonosy... You might as well do better to escape from here as soon as you can, hahaha...”

I quietly disappeared, rather intrigued by the encounter I had just witnessed. The next day on a ward round Aneta asked a doctor for a permit to get leave on

Sunday morning. To seek God's help. In that Church. She was not allowed to. Her guardian would not allow her to leave the hospital in the morning.

In her late twenties, Aneta was dressed in a sport suit, short red hair and a wide smile on her face most of the time. She liked to talk, enjoyed company of others and used every opportunity to leave the ward to go outside for a walk into the garden or a nearby town. She was not here for the first time. Her files stated no. 21. Patients often come and go, again and again. In some cases they leave and never return. In some cases they never leave. Aneta's mother is an example.

Accommodated in another ward, she lived there more than 30 years – the whole time that her daughter was alive. Her pregnancy was possibly 'an accident' but they only found out too late and she gave birth to a nice girl who grew up in a 'children's home.' She attended the school there. The school was called 'special' as it was aimed for special children – those too slow or difficult to manage in normal school. The first hospitalizations soon followed, as well as the statement of her mental incapacity and recommendation of having a 'named person' – a guardian to look after her and represent her in any legal issues. Because the only living known relative of Aneta was her mother, who had a similar arrangement and therefore could not be her guardian, the local authority named one of its officers as her legal representative.

That officer was – so to say – a professional guardian, having been 'named' for another two dozen persons. She had to be consulted and asked for permission any time Aneta was to be discharged from the hospital for a weekend leave and was supposed to visit her during that time. This woman usually called back to hospital the day afterwards saying that it is inadvisable to leave Aneta on her own : the small apartment where she stayed was a mess – or worse than that. Following her previous stay 'at home' – in one of the council flats in a nearby town, she left the place full of excrement, the floor torn up, clothes and kitchen equipment all over the place, a repulsive stench, and the doors left wide open. The police came and sealed the doors. The woman had to explain the situation to them, find cleaners and pay them twice their usual fee as they refused it to clean it for the standard price. Never again, she

said. Who would guess it? Aneta is quite nice and not aggressive, but she is not able to hold to basic hygienic and social standards. She cannot manage on her own. You should not let her leave the hospital alone and you should find another place for her once she does not require acute treatment. Until then she was allowed to share a room with five other women on this ward, all with equally miserable life histories. To me, it feels like this hospital became a place where all the human misery from this region concentrates. Medicalized, sanitized hopelessness.

## **Outline of the Thesis**

The origins of institutional care for the mentally ill in Central Europe date back to late nineteenth century when large hospitals were built within parks as self-sufficient complexes surrounded by walls, outside of large cities – sometimes former monasteries were used for the purpose. The organization of the space reflects a particular cosmology and these institutions enclosed a complete economy of life and death – including spaces for the production of food, workshops and manufacturing, and burial grounds. During socialism, these institutions remained the primary form of care for severely mentally ill patients, expressing the socialist ideology of state provided care. However, the state policies resulted in the isolation and seclusion of patients. After the fall of socialism these institutions were perceived as symbols of totalitarian power and there were attempts to introduce alternatives such as community services and assisted living – but the proposed transformation plans have not yet been implemented.

In the first part of this thesis (The Shadow of the Past) I discuss the proposed reform of psychiatry, framed within the sociopolitical and cultural changes in the course of two decades following the fall of communism in 1989. Although psychiatric care was considered in great need of thorough reform – complementing institutional care with community care and improving the conditions of life of the patients, especially the living conditions in psychiatric hospitals – and several proposals and attempts for improvement were pursued, the great hopes and expectations for systematic change did not materialize. Psychiatry in the Czech Republic remains the most under-resourced among EU countries and does not comply with international standards of care.

In examining the proposed reform of psychiatry I follow three directions in which the project of ‘humanization of psychiatry’ was directed. First, I examine the notion of social solidarity which provided the philosophical context that guided the early attempts for reform, especially the drive toward community care which was

intended to complement institutional care (Chapter 1: Solidarity of the Shaken). The disruptions and continuities with the past to which the neglect of psychiatric patients and their needs was attributed is discussed here.

I then follow the proposal for the transformation of psychiatry – a document drafted by members of the Czech Psychiatric Society for the Ministry of Health which underwent several revisions and amendments over twenty years but has never been implemented (Chapter 2: The Proposal for Transformation of Psychiatry). In describing this process I examine the negotiation of responsibility between the profession and the state in the care of the mentally ill.

Finally, I explore how the notion of human rights was adopted as a strategy for social change. Tracing the ideas back to the Charter 77, I examine the role of this discourse in the evolving national and international political context (Chapter 3: Human Rights and the Way to Europe). Although the discourse on civil society and human rights might be familiar from other countries in the Western world, in this context it resonated strongly with the emphasis on human rights as an expression of social solidarity in the Charter 77 movement. After political change was achieved in 1989, the emphasis shifted from political rights to civil and social rights and the language of human rights was used to overcome social exclusion through the integration of those previously marginalized.

I conclude this part with my own interpretation of this process, exploring the reasons why the project of the reform mostly failed, and show the importance of what did not happen while it was being hoped for (What We Missed: The Ethical Grounding of Politics).

In the second part of the thesis (Landscapes of Mental Illness) I offer a complementary perspective on the process of transformation – a view from ‘inside’ the institutions that provide psychiatric care. My ethnographic research was set in two very different institutions: the Prague Psychiatric Centre, a highly specialised clinical and research center for the treatment of acute conditions; and Kosmonosy hospital which provides acute care as well as long-term care for patients with chronic

conditions. It was in fact originally established to take care of those with ‘incurable’ conditions. These two contrasting settings allowed me to examine different aspects of the experience of severe mental illness, where the notion of curability proved to be very crucial aspect of the social responses to their conditions. I examine the ways in which medicine enters and transforms the spaces of mental illness, the ‘medicalization of hopelessness’. In this part I also devote significant discussion to the historical and cultural context of various current medical theories and institutional practices.

First I introduce the Kosmonosy hospital focusing on the experience of time, space, and life in the hospital (Chapter 4: The Spaces of Mental Illness). The design of psychiatric hospitals established in late nineteenth century as self-sufficient complexes encompassing all aspects of life and death reflects the role of social solidarity as well as exclusion in responding to mental illness. The spaces of psychiatric hospitals, their architecture and material culture which constitutes the scenery of the life of the patients is introduced in a historical context. I argue that the psychiatric hospital represents a liminal space outside of the ordinary world and in its isolated location witness the social geography of stigma.

Recounting the intellectual tradition of Czech Psychiatry from nineteenth century German Neuropsychiatry through the twentieth century era of scientific materialism I show how mental illness was always conceptualized in a way that emphasized its biological nature and lacked any significant influence of psychoanalysis (and religion), employing neurobiological as well as ethological concepts to describe and explain human behaviour (Chapter 5: The Intellectual Context of Czech Psychiatry). Drawing on the observations and narratives of patients with schizophrenia, mostly in the Prague Psychiatric Centre, I explore the ways in which this biological explanation is appropriated and transformed by patients. I describe the ways in which the patients make sense of their experience and how they adapt to life under significantly altered circumstances. In their narratives mental illness appears as a more existential rather than purely medical condition and the neurobiological concepts appropriated serve to externalize agency.



In the final chapter I examine a phenomenon I encountered during my medical training: the use of ‘unclaimed bodies’ of psychiatric patients for anatomical teaching and research (Chapter 6: Transformations: Death as a Source of Healing). The examination of this practice in its historical context offers an alternative interpretation of the condition of mental illness as a state of ‘impurity’ that has to be redeemed by medical means. These patients are temporarily or permanently suspended in spaces clearly delimited from the outside world. Their liminal status – so clearly demonstrated in the design of the psychiatric hospitals and the stigma of the illness – allows the impurity of their condition to become a means of purification through healing for others, as in the case of ‘unclaimed bodies’ of dead patients. The medical knowledge distilled from the bodies through research and teaching represents the power to cure. This practice – which continued until 1990 – can be viewed as a form of sacrifice in which illness is transubstantiated into healing.

I conclude this part by outlining the three motives that emerged from the exploration and were discussed in diverse perspectives: the role of the therapeutic environment for the healing of patients, the concept of curability and the implications for conditions deemed incurable, and the notion of the soul (Therapeutic Environment, In/Curability, and the Disappearance of the Soul).

In these discussions of the sociopolitical dimension of contemporary psychiatry (described in part one) and the institutional and personal dimension (described in part two), several common themes emerge: expectation and hope, vulnerability, solidarity and responsiveness to suffering of others, and especially the notion of humanity or humaneness in its various guises. I conclude the thesis by examining this ethical dimension of psychiatry in the perspective of Emmanuel Lévinas.

## **RESEARCH CONTEXT AND METHODOLOGY**

## **Research in the Context of Anthropological Literature**

There are several distinct areas of anthropological and social-scientific literature that are relevant to the subject of my thesis: the literature on post-socialism in Central and Eastern Europe, and on mental health care in that region; the anthropological literature on the experience of illness and suffering, social marginalization and exclusion; the literature on the rise and various uses of the human rights discourse to address various forms of inequality and discrimination. I will now introduce the themes raised in this literature that have inspired and provided comparative and interpretative perspective on my own research.

### **Post-Socialism in Central and Eastern Europe**

Tony Judt's *Postwar* (Judt 2006) presents a comparative perspective on the history of two disparate worlds, that of Eastern and Western Europe since the 1940'. Within this historical context he also interprets the emergence of a rather specific situation created by the fall of the 'Iron curtain' where 'the time of the timeless', as late socialism was described by Václav Havel, suddenly accelerated. In post-socialism, the societies of Eastern Europe have aimed to undergo a transformation that Western Europe went through over the preceding forty years. In their reflection on the sociological changes experienced by the citizens of former socialist countries in all areas of life, the writings of Claus Offe – namely the *Modernity and the State: East, West* (Offe 1996), and his edited volume (with a very apposite subtitle) *Institutional Design in Post-Communist Societies: Rebuilding the Ship at Sea* (Elster and Offe 1998) – are among the most significant for conceptualizing the post-1989 situation in a comparative perspective. He notes that this politico-social transformation took place 'in the dual context or cognitive frame of reference and comparison of 'the West' and 'the past'.' It is this dichotomy that I found pervasively present in accounts of my informants where 'the West' or 'Europe' has been understood also in a temporal sense, as a future towards which we have to strive and, in order to become part of the future, it is necessary to dispose of the heritage of

forty years of communist rule. This spatiotemporal understanding of recent history pervaded my informant's accounts of the proposed transformation and reform of psychiatric care. However, as the most recent historical studies (for example, Judt 2006) have shown, transformation as a move from the past towards the future is always inevitably preliminary and incomplete: the imagined future does not coincide with the real one and the past remains present in many subtle as well as more tangible ways. What is significant is the emphasis on discontinuity itself, as it has been pertinent to all the debates of that time. Czech sociologist Zdeněk Konopásek warns about the danger of 'schematic conceptions' where it is

"explicitly or implicitly assumed, that East European communism and Western democracies represent two incommensurable worlds. The flourishing discourse of Transformation emphasized the aspects of radical change and difference, while playing down temporal and spatial continuities. ... In order to understand these differences we should not explain them by simple referring to some essences of totalitarianism (and democracy) or communism (and capitalism). We should not replace careful study of a number of small, ordinary, partial, politically or ideologically unspectacular or even controversial dissimilarities by the rhetoric of two incommensurable realities, so radically disparate that any closer scrutiny of particular differences or similarities is necessarily meaningless. We need comparative insights sensitive to specific local and historical contexts and suspicious towards big and established notions or categories safely partitioning the helplessly complicated world." (Konopásek 2006).

I therefore aim to provide an account that treats references to the 'democratic' or 'totalitarian', and to 'West' and 'East' as rhetorical resources, as a strategy or instrument to endow with power what contrasting of various practices, rather than consider these as reified, absolute categories. This approach allows to portray and examine cultural continuity under the surface of political discontinuity.

Given the recent shared historical experience it comes as no surprise that many of the issues addressed in my research resonate with the post-socialist situation in various countries in Central and Eastern Europe. Over the last century similar policies were enacted in these countries, and the abrupt end to the Soviet empire opened the possibility of a sudden import of ideas, discourses, and practices that have developed in the West over the past forty years. This should not however be seen as a process of substitution but rather as a fusion: the new interacted in various

often unpredictable ways with the former and current situation and created variations that are unique to this part of Europe. Under the rhetorics of discontinuity there are strong undercurrents of continuity: engrained practices that have their own momentum and are indolent to change. The present intellectual tradition has also exerted influence over the reception of the new ideas, practices, and ideologies. What is especially relevant to this thesis is the human rights discourse of the dissent movement and its transformation after direct exposure to the Western liberal tradition.

Although inspired by the Helsinki Accords – firmly grounded in the classical liberal tradition – human rights in the Charter 77 were nevertheless understood in the language of phenomenological and existential philosophy (Shore, IWM) – that of human solidarity and responsibility in the face of fragility of human life. The impact of the intellectual tradition on the political life of dissent has been examined by Aviezer Tucker in his book *The Philosophy and Politics of Czech Dissidence from Patočka to Havel* (Tucker 2000) and the post-1989 appropriation of the western discourse on human rights and its implication for different areas of political life has been described in Jan Jařab *Very Slow Revolution* (Jařab 2006). Miloš Havelka examines the historical context of the concept of ‘non-political politics’, which has influenced and transformed the notion of ‘civil society’ (Havelka 1998). The rise of a new generation of political elites in 1968 and in the early nineties and the ways in which they directed the civic life in the light of the continuities and discontinuities with the past has been examined by Gil Eyal (Eyal 2003). The distinction between the ‘political’ and ‘non-political’ aspects of social life as understood by various actors in the political situation informs my interpretation of the events described in the first part of my thesis.

The anthropological studies of post-socialism have also been numerous – although most of them primarily focused on the political and economical aspects of transformation (Bridger et Pine 1998; Burawoy et Verdery 1999; Hann 2002; Mandel et Humphrey 2002). Ladislav Holý’s essay on the *End of Socialism in Czechoslovakia* in Chris Hann’s collection *Socialism. Ideals, Ideologies and Local*

*Practice* (Hann 1993) recounts the events and examines the discourses related to the change of the regime in Czechoslovakia, which he further elaborated in his 1996 book *The Little Czech and the Great Czech Nation. National identity and the Post-Communist Social Transformation*. Examining the rhetorics and symbolism of the revolution, he notes that these are surprisingly similar at different times in Czech history which recently underwent several political turning-points (1918, 1948, 1968, 1989), with emphasis on the moral decline of the previous period and the idealized, often utopian future. This moral interpretation of history was very tangible in the discussions about psychiatry in early nineties and, as a confirmation of Holy's observation, similar rhetorics were used to exalt the implications of new communist regime for the wellbeing of patients in nineteen sixties as I will demonstrate in chapter two.

Hann's subsequent volume *Postsocialism. Ideals, Ideologies and Practices in Euroasia* (Hann 2002) offers several essays discussing the conceptual issues of framing the current historical Central and Eastern European situation as 'post-social' (Hann, Humphrey, Verdery). I appreciate some of their concerns regarding the use of the term 'post-socialism' such as the problem of the diversity of what 'socialism' represents in different contexts, the problem of the continuities of various social practices despite political change, and the problem of the regret and nostalgia that socialism might evoke in critiques of the 'post-socialist'. Throughout my thesis, however, I use this term in an historically descriptive rather than in an analytical sense. Although my research on psychiatry is situated within the post-socialist condition, 'post-socialism' represents more of a background than a subject of my research as such. However, Hann's suggestions that post-socialist anthropology has to engage with both the political and the ethical dimensions of transition societies and that it is necessary to recognize the moral complexities of social change represent challenges to which my thesis responds at least in part.

## **Mental Health Care in Central and Eastern Europe (CEE)**

Although there is no comprehensive study of psychiatry and mental health care in CEE, there are several historical studies from Czechoslovakia (Hoffman 1997) and also some recent anthropological studies from this region. Most of them examine the aftermath of socialism and the introduction of neoliberalism and their impact both on patient's lives and on the healthcare systems. Vieda Skultans examined the narratives of psychiatric patients and the changing notions of individual responsibility for illness in Latvia (Skultans 2007; 2011). Shelly Yankovsky writes about the impact of neoliberal ideology on mental health care in the Ukraine (Yankovsky 2011). C.P. Korolenko and D.V. Kensin explore recent changes in Russian psychiatry (Korolenko et Kensin 2002). J.R. Friedman examines how the neoliberal ideology penetrates psychiatric care in Romania (Friedman 2009). One common motive in these accounts is the shifting responsibility for mental health care from the state to that of family and individual which all authors attribute to the demise of the paternalistic practices of the state and the rise of individualistic neoliberal ideology. However, on closer inspection, the reality seems to be more complex than what can be attributed merely to the appropriation of new ideology. In her essay on 'Inequalities in Health and Healthcare in Post-Communist Europe' Peggy Watson claims that the *"transformation of health care has been among the most problematic sites of transition to democracy from communism – and little is known of its effects"* (Watson 2007). The effects of (partial) privatization of healthcare and administrative de-centralization often resulted in fragmentation and lack of quality and continuity of care, which is especially significant in an area of mental health where it is often on the initiative of patients and their families to access the care they need. The rise of social inequalities and the collapse of social support networks in many of these countries certainly contributes to the changing landscape of psychiatry and mental health care as an unintended effect of abrupt changes in social policies – or lack thereof. However, there are also social and cultural patterns that developed historically and which continue under the surface of change in political rhetorics, and these continuities are equally worth examining.

Additionally, several publications in the area of mental health and social policy in Europe which address the situation in CEE in a comparative context are relevant for my research (Knapp et al. 2007; Scheffler et Potůček 2008), as well as a significant number of journal reports (Rittmannsberger and Sartorius et al. 2004; Becker and Kilian 2006; Tomov 2001; Kallert et al. 2005 and 2007; Lewis 2002; Tannsjö 2004). Through participation in several conferences devoted to the transformation of health care in CEE – especially the 2008 Fogarty Conference which brought together psychiatrists, researchers and policy makers from various CEE countries on the initiative of the US research centre at Berkeley, the 2008-2010 EU project on the physical health of patients in mental health care institutions (HELPS)<sup>1</sup>, and the 2011 ‘Health in Transition’ Conference which brought together anthropologists working in this area – I was able to meet and work with people working on relevant issues in this region. While there are many issues in the area of psychiatry and mental health that are specific to the CEE region – for example, discussions about de-institutionalization, the lack of collaboration and coordination of health care and social care services and the overall lack of resources for improvement of mental health care – stigma and discrimination seem to be experienced in all the contexts I encountered, including Western Europe, USA and Israel, although the actual forms often differ in nature and degree.

### **The Suffering Subject**

There is a wide range of literature on the experience of illness and pain and the social response to it, although the Harvard tradition of medical anthropology has perhaps been most influential. The 1988 publication of Arthur Kleinman’s book *The Illness Narratives* (Kleinman 1988) examined the subjectivity of the experience of pain, illness and suffering and inspired numerous ethnographies exploring these themes in a wide variety of contexts. In his next book *Rethinking Psychiatry: from cultural category to personal experience* Kleinman proposes that the general

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<sup>1</sup> European network for the assessment and improvement of health related lifestyles and physical health status in psychiatric inpatients. See BMC Public Health 2009, 9:315



psychiatric categories are shared universally but are nevertheless experienced and interpreted differently depending on the cultural context (Kleinman 1991). This book inspired me to examine the particular cultural and historical context of contemporary psychiatric practice in the Czech Republic, as an example of the Central and Eastern European context with the legacy of socialism and marxist ideology.

One of the distinct characteristics of psychiatry in Czechoslovakia is the lack of influence of psychoanalysis, which had very strong position in other contexts as documented in the work of Tanya Luhmann in the US as she explores the shift from psychodynamic to neurobiological understanding of mental illness (Luhmann 2001), in Dominique Béhague's work in Brazil where the rise of biological psychiatry coincided with the neoliberal sociopolitical change (Béhague 2009), and in Argentina explored by Andrew Lakoff (Lakoff 2003; 2004; 2007). These studies provide important insights into how specific forms of knowledge are associated with specific sociopolitical situations and how the knowledge and various explanatory models of illness can become a form of ideology entangled with political agendas. In the context of Czechoslovakia, psychodynamic and existentially oriented therapies flourished in the underground, unofficial culture of dissent, and later influenced the ideals that attempted to guide the transformation of psychiatry into a more 'humane' place, as I describe in chapter one.

Writings inspired by phenomenological and existential traditions thus became relevant for my research context. Among the most significant volumes are *Pain as Human Experience* by Arthur Kleinman and his colleagues (Kleinman 1992) and Thomas Csordas's edited volume *Embodiment and Experience: The Existential Ground of Culture and Self* (Csordas 1993) which explore a dialogue between the phenomenological and existential traditions in addressing the subjectivity of experience of illness, suffering, and finitude. Again, the existential and phenomenological tradition has had a rather different trajectory in my research context and I am using it as an interpretive instrument. The edited volume *Schizophrenia, Culture and Subjectivity: The Edge of Experience* (Jenkins and Barrett 2004) examines specifically the experience of psychosis and schizophrenia

and the essays collected in this volume portray different ‘colourings’ of the experience according to the specific cultural contexts. However, this book also portrays surprisingly similar patterns in the social responses shared across these contexts, namely the loosening of human ties as a result of mental illness and the subsequent marginalisation within the society, as described in chapter 4. These patterns are described and analysed in detail in Robert Desjarlais’ *Shelter Blues* (Desjarlais 1997), an ethnography of the life of the homeless mentally ill in the Boston area, and João Guilherme Biehl’s *Vita: Life in a Zone of Social Abandonment* (Biehl 2005), an ethnographic examination of mental illness and social marginalization in Brazil. Both of these focus predominantly on the lives of individuals through which they examine patterns of social exclusion – an approach I was not able to take due to methodological/ethical concerns as I shall describe later. However, their portrayal of the estrangement and isolation of the individual is surprisingly similar to experiences of patients I encountered during my fieldwork.

The experience of estrangement thus seem to be an inherent and universally shared characteristic of the experience of mental illness. This notion is explored on both personal and social level in some of the essays and case studies collected in *Social Suffering*, (Kleinman, Das, Lock et al.1997). Here the emphasis moves from the subjective experience to the examination of the sociopolitical circumstances that shape the experience of suffering and often result in social marginalization, exclusion and structural violence. Another volume that adopts a similar approach is *Subjectivity: Ethnographic Investigations* (Biehl, Good and Kleinman 2007) which examines the experience of vulnerability and suffering in particular sociopolitical contexts – several of which address mental illness, for example Corin’s contribution.

Other monographs that have emphasized the interdependency of the personal experience within the social and political structures and institutions are Adriana Petryna’s *Life Exposed* (Petryna 2002) and Paul Farmer’s *Pathologies of Power* (Farmer 2003). Petryna examines the effects of state policies (or their non-existence) in the aftermath of the biological disaster in Chernobyl, Ukraine, where the weakness of the state left the victims of the disaster abandoned without any compensation. The

failure of the state impacts the experience of harm and helplessness of the affected deepening their misery. While exploring this interdependency further, Farmer frames the issues of suffering in Haiti as structural violence perpetrated on the victims of an unjust social order – thereby moving from the descriptive to the normative. He argues for the alleviation of suffering and misery as a demand of human rights, a discourse which endows individual experience with universal validity. This emphasis on universal human rights is rather symptomatic of the increasing influence of the human rights discourse on the debate over access to medical care worldwide, often articulated as the right to health. In the Czech Republic, however, the issue of access to care has not been seen as an urgent problem due to obligatory health insurance, while the target of the human rights critique were the paternalistic practices and the lack of respect for the rights of patients in institutional care.

This critique of the paternalistic practices of the state and medical profession which deprives patients of their dignity and rights has been present in humanities and social sciences literature for some time. Among the most influential social science writings examining the sociopolitical context of the treatment of patients suffering from mental illness are the writings of Michel Foucault (Foucault 1964; 2006), Erving Goffman (Goffman 1961) as well as the psychiatrists Thomas Szasz (Szasz 1961) and R. D. Laing (Laing 1960) in the early 1960'. These writings significantly influenced the 'anti-psychiatry' movement in the West and provided intellectual justification for the deinstitutionalization policies since the late 1970'. However, these arguments were framed as social and political oppression, the coercion and abuse of individual freedom by society, while the emphasis on individual human rights as entitlements is of more recent origin. Czechoslovakia has not gone through this phase and the anti-psychiatry discourse emerged only recently in the work of several international NGO's concerned with patients' rights. While the earlier literature emphasized the negative power that the society exerts over the individual, the new discourse attempts to rescue the freedom and agency of the individual on the background of universally shared human rights.

This shift of emphasis is examined by Elizabeth Anne Davis in the context of contemporary Greece and her ethnography shares many similarities to my own research context. Her monograph *Bad Souls: Madness and Responsibility in Modern Greece* examines the aftermath of psychiatric reform undertaken by Greek state since early eighties – a process which was initiated by the accession of Greece to European Union, driven by the human rights discourse as well as neo-liberal transformations (Davis 2012). In 1989, the conditions of the psychiatric hospital on the island of Leros were publicized in world media with images of patients kept in chains and wandering around naked. As a result of strong criticism for the infringements on human rights by the international community, Greece initiated a reform of psychiatric care with the expertise of foreign policy makers and funding from the EU, adopting deinstitutionalisation and the introduction of community care. In Greece, as well as later in various Central and Eastern European countries, the transformation of mental health care was considered part of the project of modernization and political liberalization and reflected the ambitions of belonging to the international clique of progressive states gathered in the EU. This process coincided with the rise of neoliberal rhetorics penetrating the policies of modernisation, as well as the increasing prominence of the human rights discourse. Davis examines the shifts in the understanding of rights and responsibilities for health and their implications for the lives of individual patients.

In many ways my research in Czech Republic complements Davis' research. The two countries (Greece and the Czech Republic) had similar aspirations in pursuing reform and were using similar instruments of human rights discourse and pressure from the international community. The major difference is that in the Czech Republic these reforms did not occur despite being discussed and hoped for.

### **Human Rights and Health**

In the context of medicine, human rights discourse has a long tradition in various declarations and policy documents. Many World Health Organization

policies are introduced with reference to human rights declarations. Indeed, the WHO 1946 Constitution defines health as a basic human right: “*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*”<sup>2</sup> Jonathan Wolff’s *The Human Right to Health* examines this proposition in both historical and international context (Wolff 2012). Additionally, a book by Ann Taket, *Health Equity, Social Justice, and Human Rights* provides a general overview and several case studies of the employment of the human rights approach in the area of public health (Taket 2012). An overview of various initiatives using human rights to secure dignity for people with mental disabilities was published in PLoS (Yamin and Rosenthal 2005). The journal *Health and Human Rights* publishes contributions presenting normative arguments framed in the human rights discourse to inform public policy.<sup>3</sup> An article by Jonathan K. Burns, for example, demonstrates this approach in the area of mental health (Burns 2010). Another recent example of the attempt to overcome stigma, discrimination and inequality resulting from mental illness by constituting it as an issue of human rights and social justice is the European collaborative project by prominent scholars resulting in the edited volume *Mental Illness, Discrimination and the Law: Fighting for Social Justice* (Callard, Sartorius et al. 2012). In the case of Czech psychiatry there has rarely been any reference to social justice, and the discourse on human rights has been used primarily in the context of the rights of individual patients in institutional care, focusing on the restrictive practices in the hospitals.

Referring to Article 5 of the 1946 Universal Declaration of Human Rights of the United Nations which states that “*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment*”, the Council of Europe issued a *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* and established ‘Committee for the Prevention of Torture’ with the mandate to visits places within where persons are deprived of

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<sup>2</sup> <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

<sup>3</sup> <http://www.hhrjournal.org/index.php/hhr>

their liberty by a public authority in order to assess how persons deprived of their liberty are treated – these included psychiatric hospitals and social care homes.<sup>4</sup> The European Convention for the Protection of Human Rights and Fundamental Freedoms also serves as a basis for decisions at the European Court for Human Rights.

Although there is not yet enough critical literature on the ways in which the concept of human rights is employed in the contexts of health care and psychiatry, the complexities of deploying human rights discourse have been examined carefully in other contexts, for example by Didier Fassin in the context of humanitarian intervention (Fassin 2011; Fassin and Rechtman 2009) and asylum policies (Fassin and d'Halluin 2007), and by Tobias Kelly in the context of experience and recognition of torture (Kelly 2011, 2012). As they observed, the success of framing the claim in terms of individual rights all too often depends on other resources, such as the claim to compassion for the suffering Other. Moreover, the focus on individual rights often obscures the claim to social justice. This approach more often than not fails to alleviate conditions which in other contexts have been framed as ‘structural violence’ (Kelly 2005).

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<sup>4</sup> <http://www.cpt.coe.int/en/documents/eng-convention.pdf> and <http://www.cpt.coe.int/en/about.htm>

## Psychiatry in the Czech Republic in a Historical Context

The institutional and intellectual history of psychiatry are inevitably intertwined as the establishment of hospitals and institutions devoted to the care of the mentally ill coincides with the rise of psychiatry as a medical discipline. Medical practices and theories of the early days of psychiatry in this region were significantly influenced by the neurological tradition of German speaking countries where mental illness was understood to be caused by disordered processes in the brain. In 1919 the ‘Society for the Study of Soul and the Nervous System’ was established as a neuropsychiatric branch of the Medical Association of Jan Evangelista Purkyně. Although in 1955 the Czechoslovakian neuropsychiatric society was divided into two sections – one for neurology and one for psychiatry – psychiatry always retained its biological orientation. Czech psychiatry follows the WHO International Classification of Diseases (ICD-10).

In Czech the term ‘psychiatry’ refers to both the medical discipline incorporating the corpus of medical knowledge about human nature and its pathologies, and to what that in English would be more appropriately referred to as ‘mental health care’. Although there is an equivalent term for mental health care in Czech (*péče o duševní zdraví*) it is very rarely used and even in policy documents it is often referred to as psychiatry or psychiatric care. The term ‘psychiatry’ throughout the thesis thus incorporates both of these aspects.

Over time, psychiatric hospitals have oscillated between being governed by the ministry of health and by the local authorities. Until 1950 they were directed centrally by the ministry of health (or their equivalent in the Austrian-Hungarian era) as an administrative category separate from general hospitals. In the socialist era (1950-1990) although they were governed by centralized policies they were in the responsibility of the regional administrations. In 1990 this arrangement changed and all psychiatric and university hospitals are administered directly by the Ministry of Health while general hospitals (some of which do have psychiatric wards) are either under regional administration or became private.

## 1. Psychiatrické léčebny pro děti a dospělé



## 2. Psychiatrická oddělení nemocnic

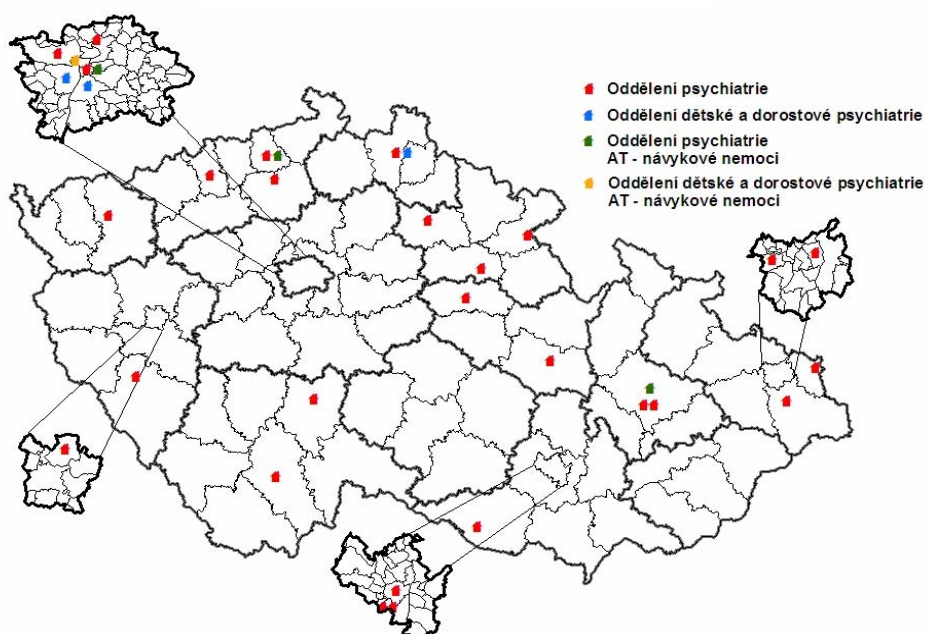


Figure 1: Location of Psychiatric Hospitals in the Czech Republic (ÚZIS ČR 2008)

1. Psychiatric sanatoria for adults (blue) and children (pink)
2. Psychiatric wards in general hospitals – adults (red), children and adolescents (blue), treatment of alcoholism and addictions for adults (green) and children and adolescents (yellow)

There are three distinct types of hospitals providing in-patient care: (1) psychiatric wards in university hospitals (*psychiatrická klinika*) in major cities which



in addition to clinical care are involved in research and in the teaching of medical students; (2) psychiatric wards in general hospitals which are relatively small in capacity and located in larger district towns with a specified catchment area (*psychiatrické oddělení nemocnice*); and (3) large asylum-type hospitals called sanatoria (*psychiatrická léčebna*)<sup>5</sup> with large catchment areas of one or several regions (Figure 1 – Location of Psychiatric hospitals in the Czech Republic). The establishment of these institutions can be divided into three distinct historical phases:

*Phase I.* Establishment of hospitals in the late Austrian-Hungarian empire.

Although the first psychiatric hospital in this region was established already in 1788, the expansion of state care for the mentally ill with a centralized structure and the formation of the profession developed in the late nineteenth and early twentieth Centuries as a result of the policies of Austrian-Hungarian Empire. These hospitals which were established as institutions for several hundreds or even thousands of patients coming from a large catchment area represented a special category as ‘institutions for insane’. Together with general hospitals, maternity hospitals and ‘institutions for foundlings’ were regulated by the ‘Act on Therapeutical and Humane Institutions’ (1888, 1920). These hospitals are called psychiatric sanatoria (*psychiatrická léčebna*) and are similar to the institution of asylum in the Anglo-Saxon tradition. This era is often referred to as a ‘custodial care’ period due to the limited repertoire of treatment options. Most of them represent large complexes close to but beyond the borders of district towns, and in some cases former monasteries or castles were used and transformed into hospitals. Originally, they were designed to accommodate both patients and staff.

In 1918 Czechoslovakia emerged as a separate state from the war, however, the health care policy did not change significantly in the interwar period. Several private practices were established to provide medical treatment for mentally ill patients to complement the institutional care. In 1938 significant parts of the country – the Sudeten – were formally annexed to the German Reich and policies affecting

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<sup>5</sup> Recently (after 2010), all psychiatric institutions have been renamed ‘psychiatric hospitals’ in an attempt to shed off the stigma associated with large sanatoria and emphasize their curative role.

the mentally ill were enacted in this region, the most infamous of which was the T4 euthanasia programme. The rest of the country became a German protectorate and was affected by the scarcity conditions of war. The conditions in the psychiatric hospitals worsened significantly as a result.

*Phase 2.* Establishment of psychiatric wards in general hospitals and the integration of psychiatry into primary care after 1950.

After the war and as a result of socialist policies of the communist party that came to reign in 1948, the healthcare was nationalised and centralised and the state became the sole provider of care. Significant reforms to improve the accessibility and quality of care were enacted while the emphasis was on primary care. In the nineteen fifties specialist out-patient treatment options significantly expanded, and specialised wards associated with general hospitals were established (*psychiatrické oddělení nemocnice*) to provide a wider spectrum of care mostly for acute conditions. Some of these wards were parts of university hospitals (*psychiatrická klinika*). The proposal to integrate psychiatric care into primary care in order to improve the mental health of population resulted in a centralized network of psychiatric outpatient services. This shift of emphasis was also facilitated by introduction of new forms of treatment by means of psychopharmacology that allowed for the immediate management of acute illness in the wards of general hospitals, and assisted living outside of the hospital. Also, in early fifties, a general inspection by the Ministry of Health in psychiatric hospitals led to the closure of several institutions where the poor material conditions endangered the health of the patients.

As a part of state policy to strengthen the mental wellbeing of the population, the Psychiatric Research Institute (later renamed as Prague Psychiatric Centre) was established in 1961 to study both biological and social dimensions of mental illness. This mission was derived from the then popular Marxist philosophy which conceptualizes persons as the intersection of biological and social forces. From the perspective of other forms of treatment, the behaviorist, and partly also the social-engineering approaches to mental illness were therefore dominant in the second half

of the twentieth century. Given the prevalence and influence of psychoanalysis in many other medical traditions of Western Europe and USA, its absence in official psychiatric doctrine might be retrospectively surprising, but this approach was well in accordance with the ideology of this time in Central and Eastern Europe.

However, the psychoanalytical tradition and various forms of psychotherapy were practiced unofficially, and there were many personal ties with the underground dissent movement among psychiatrists. The emergence of 'biological psychiatry' in the West since the eighties was therefore hardly recognizable as novel although it facilitated the rapid expansion of psychopharmacological market after the fall of socialism.

The number of specialist physicians trained in psychiatry reflected the growing demand for these services – from 0.9 per 100 000 population in 1960 it increased to 3.9 in 1989 (an increase of 60% in inpatient settings, and 479% in outpatient settings). Also, the number of contacts with psychiatrists in outpatient services increased significantly by 431% in the same time period – from less than four contacts per 100 population in 1960 to more than 15 in 1989 (Psychiatrická péče 1960-1962; 1980-1997).

*Phase 3.* The introduction of intermediary care, therapeutic sanatoria and rehabilitation programs to complement the care of hospitals and outpatient specialists.

The first of these intermediary forms of care were introduced as early as 1948 (Skála's treatment of alcoholism), followed by two day sanatoria in 1960 and 1968, and two more in the eighties with an emphasis on psychotherapy to complement to other forms of treatment and care. In Western Europe, introduction of community services in the seventies was related to the process of 'deinstitutionalization', where the large hospitals were being closed – often as a result of the critique of the anti-psychiatry movement and changes in the state policies. The fall of socialism in 1989 was seen as an opportunity to transform psychiatric services. The main aims were to complement institutional with community care, to transform the structure of

psychiatric services across the regions, to improve the living conditions in the psychiatric hospitals and to strengthen the role of the psychiatric wards in regional hospitals in order to make the services more easily accessible and diverse with respect to the various needs of the patients. Since these forms of care represent the intersection of health care and social care, they have a rather ambiguous status with unclear division of responsibility between the Ministry of Healthcare and the Ministry of Labour and Social Affairs – which proved to be one of the main obstacles to implementing the proposals for transformation of psychiatric services.

Psychiatric sanatoria were built as facilities to accommodate patients from large regions (their current capacity ranges from 600 to 1600 beds), and often are located remotely without convenient public transport. The distance from a patients' home can be up to 200 km – which contributes to the isolation of patients from their families. Since 1990 there has been a decline in number of beds in psychiatric institutions (12%), which is mostly due to attempts to improve conditions for patients. In order to increase the availability and accessibility of services and improve the quality and continuity of care there has also been an attempt to establish new psychiatric wards in district hospitals. The size of psychiatric wards in general and university hospitals ranges between 30-60 beds and allows for a more individualized approach to care. The ratio of staff to patients is based on different systems of financial reimbursement of care and is more favourable to general hospitals which can thus afford to employ more physicians, nurses, other therapists and social workers. Among other factors, the lack of staff in large sanatoria often inevitably results in the greater use of coercive measures and poorer quality of care.

As of 2008, in the overall population of 10.468 million there were 16 psychiatric sanatoria for adults with the overall capacity of 9,240 beds (average length of stay 86.2 days), and 32 psychiatric wards in general hospitals and university hospitals with the overall capacity of 1396 beds (average length of stay 19.7 days).<sup>6</sup> Additionally, there were 948 outpatient psychiatric specialist offices to

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<sup>6</sup> All following data taken from Psychiatrická péče 2008 and Baudiš 2006.

provide care and treatment in the community. In 2008, there were 2,550,180 individual psychiatric consultations/treatments provided by psychiatrists, 18,258 hospitalizations in psychiatric wards in general hospitals and 39,138 in psychiatric sanatoria. The most common diagnosis (ICD) on admission was schizophrenia, schizotypal and delusional disorders (F20-F29) accounting for about a fifth of the overall hospitalizations (105.5 hospitalizations per 100,000 population) – the condition to which most of my attention in this thesis is devoted. Other most common diagnoses are conditions caused by alcohol and other psychoactive substances abuse (F10-F19) and neurotic disorders (F40-F48 and F50-F59). 49% of patients discharged from hospitals require permanent follow-up care with an additional 33% requiring temporary follow-up care. In the case of schizophrenia, more than 72% of patients require permanent follow-up care. In 2008, 1,771 patients died in psychiatric hospitals with 97% of deaths occurring in psychiatric sanatoria (38% of them had postmortem examinations).

The total number of psychiatrists is 1,270 (proportionally similar to EU average), of which 643 work as outpatient specialists, 487 work in the psychiatric sanatoria, and 146 working psychiatric wards in general hospitals and the total number of nurses is 4,200 (2-3x less than average in EU countries).

## **Legal framework**

In the Czech Republic health care provision is universally guaranteed and regulated by the Health Care Act of 1966 with subsequent revisions in the 1990s and 2000s (previous acts regulating health care were passed in 1951, 1920 and 1888, reflecting the changes in political governance). Although the drafting and passing of new comprehensive health care legislation to facilitate transformation of health care services has been on agenda since 1990, the political situation has not been favourable to passing any comprehensive legislation. Therefore, the amended socialist Health Care Act of 1966 still represents the legal framework for healthcare provision. The most significant revision was the introduction of obligatory health

insurance (1991, 1993, 1995) with insurance companies regulating the healthcare provision by way of the reimbursement of services (which has proved to shape the forms of health provision more than the state policies). De-centralization of healthcare provision to the municipalities and regions and changes in ownership of health care providers with subsequent partial privatization (1991, 1992, 2006). There were transfers of ownership and legal rights from the Ministry of Health to regional governments and municipalities, however, university hospitals and psychiatric sanatoria remain directly under the Ministry of Health. The organizational and economic changes introduced after 1990 led to the loss of integration and coordination of health care services provision and adversely affected both the quality and the continuity of care. The privatization of outpatient specialist practices in late nineties led to the fragmentation of care: the previous model with a physician working with a nurse and in some cases also a social worker was abandoned on economic grounds in favour of the physician only model of outpatient care. As a result, the prioritization of psychopharmacology over psychotherapy and other forms of treatment was strengthened as a consequence of new reimbursement systems.

Legislation in the early nineties also granted greater autonomy to professional bodies (for example, the Medical Chamber and professional medical organizations) and health care providers. Among the first significant changes for the patients was the right to choose a physician and healthcare facility (1991 – previously this has been assigned by the location of residence), the Charter of Rights of Patients (1992), and new regulation of patient confidentiality and access to documentation that increased the autonomy of the patient (2000, 2007). Further development of health care policy was rather inconsistent due to frequent changes at the ministry of health and the preoccupation with the economic aspects of transformation and there is no mental health policy department to guide development in this area. However, there are several international documents and treaties signed by the Czech Republic that could potentially impact the provision of mental health care (WHO Health 21 – WHO 1998; Green Paper on Mental Health in Europe – EC 2005; the European

Declaration on Mental Health – WHO 2005; and Mental Health Action Plan for Europe – WHO 2005) although they have not yet been implemented.

In many ways mental health care represents the intersection of health care and social care and social care policy has a significant impact on the services available to patients. The disability support for which many patients with severe mental illness are eligible is administered by the Ministry of Labour and Social Affairs and covered by social insurance through Social Security Administration. The other legislation relevant for mental health care is law on social security insurance (1990, 1992), the law regulating charities and non-governmental organisations (1996), and especially the comprehensive Social Care Act (2006) which introduced contractual relations in service purchasing by individual clients. This move was supposed to strengthen the autonomy of the clients (or service-users, as in some recent documents) and had an impact on the range of services available in the community.



Administrative building, Church of St. Wenceslas, and Water Tower, Bohnice hospital (archive)

## **Financing Health Care**

One of the key issues in the post-socialist transformation was the privatization of the economy in the spirit of neo-liberal principles that were to de-emphasize the role of the state. The former model of financing health care through general taxation (as in the UK and Scandinavia) has in early 1990' been abandoned in favour of the insurance based model where the state mandates resources through the health insurance market. The obligatory health care (and social care) insurance was introduced in 1993, and all employers, employees and state contribute to insurance fund. The introduction of health care insurance system shifted power from the state to the healthcare insurance companies. The insurance companies gained the power to regulate the numbers of practicing physicians and treatments offered by means of contract limitations and reimbursement regulation. Until recently, all medical care was provided free of charge and only in 2008 a co-payment was introduced for office visits and hospital stays. Some medication also require co-payments which, in the case of antipsychotic medications can reach significant amounts.

Psychiatry is a significantly under-resourced sector within the health care system in the Czech Republic. The statistics indicate that 2.7-3.7% of the health care budget is devoted to psychiatry (Dlouhý 2004; Pěč 2003; Škoda et al. 1998). Currently the average within European countries is around 8% (with 11% recommended). Reimbursement is negotiated between the health insurance companies, organized groups of providers, and the Ministry of Health (Scheffler and Potůček 2008). General practitioners, outpatient psychiatrists and all clinical psychologists are reimbursed by capitation, complemented with a fee for service for additional treatments such as psychotherapy. The insurance companies also stipulate the maximum possible expenditures for outpatient specialists, which has significant implications for the provision of care. Reimbursement for inpatient hospital services is based on a 'per capita/per day' system. Psychiatric hospitals account for 35.6% of mental health expenditures, specialized outpatient services for 17.4%, and prescription drugs and medical devices for 33.2% (Dlouhý 2004).



## Research Design and Methodology

My research into different aspects of psychiatry in the Czech Republic can be divided in three main phases: archive and library research (10-12/2006); fieldwork in Prague Psychiatric Centre and Kosmonosy hospital (1-12/2007); and additional interviews with psychiatrists, policy makers and activists, with occasional visits to centers providing day care and shelter housing, as well as several other hospitals and out-patient departments (between 2006-2010). Additional details concerning my work in each of these research phases with detailed information about the hospitals and other institutions and organisations involved in the area of mental health care (professional societies, governmental bodies, non-governmental organisations in the area of community care, human rights initiatives and patients' organisations) are described in Appendix 1.

The two hospitals where I did my fieldwork were selected to offer comparative perspectives on psychiatric care. The Prague Psychiatric Center is a clinical and research center affiliated with the Third Faculty of Medicine of Charles University.<sup>7</sup> It is located at the premises of the large psychiatric hospital in Prague Bohnice (1300 beds).<sup>8</sup> Its inpatient capacity counts 50 beds in three separate wards and it provides clinical care to patients with the first onset of psychiatric disorders with generally good prognosis. The Kosmonosy hospital is located in a village 60 km north of Prague and with its 600 beds is among the smallest of the sanatoria type hospital which have usually capacity of 1000-1800 beds.<sup>9</sup> This hospital has a large catchment area and in addition to its acute wards it also provides long term care for patients suffering from chronic illness – indeed, it was originally founded as an institution for ‘incurable patients’. It has specialised wards for care of patients with chronic conditions, geriatric wards for elderly psychiatric patients, patients with combined developmental (severe learning disabilities) and psychiatric disorders,

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<sup>7</sup> <http://www.pcp.lf3.cuni.cz/pcpout/>

<sup>8</sup> <http://www.plbohnice.cz/>

<sup>9</sup> <http://www.plkosmonosy.cz/>

disorders of sexuality, and a forensic ward. These hospitals represent two entirely different worlds with rather different therapeutic prospects for their patients, and, after studying them more closely, the notion of curability became one of the key concepts around which my interest evolved.

The research had a slightly different focus in each of these places. In the Prague Psychiatric Center I focused on the transmission of knowledge and specific ways of thinking about mental illness, and was able to conduct interviews with individual patients suffering from schizophrenia. In the Kosmonosy hospital I focused mostly on the provision of care and the interactions between medical professionals (not exclusively medical doctors) and patients and I was able to spend more informal time on the wards with patients.

My research interests were informed and shaped by my previous experience working as a medical doctor in a child psychiatry hospital and teaching ethics to medical students at the university. While I trained in child psychiatry I soon encountered the limits of medicine in curing mental illness – not only because medical science does not know enough of the very subtle processes of human brain, but also because human relationships and social environment represent significant factors in altering the course of the illness. When treating young patients in an acute ward of a university hospital we were often faced with the dilemma of which environment would provide them with more support in their recovery and meet their various – not only medical – needs. There were very few options available: either return to the family, which in many cases was a contributing factor for developing mental disease or for other reasons might not be the most desirable environment, or placing them in a longer term psychiatric hospital, or placing them in a ‘disturbed children’s home’ – an institution devoted to troubled youngsters, many of them with criminal history. I soon realized how the structural and institutional circumstances constrain the prospect of good quality treatment and care for our patients.

My approach to the research has been partially influenced by phenomenology and hermeneutics – describing and examining social phenomena and interpreting

them through their context. One emphasis of phenomenology as originally conceived by Edmund Husserl was to 'bracket-out' all a-priori concepts that might illuminate but also obscure the 'givenness of things'. Where possible, I have therefore used the common understanding of social processes related to sociopolitical change by people living in Central Europe as well as the medical discourse by medical professionals in order to interpret their meaning through the context in which they were lived, understood, and reflected upon. Although often the same general concepts are used, the historical and cultural tradition endows them with a very particular meaning. I have therefore intentionally avoided some of the concepts often used in anthropological discourse (structural violence, biological citizenship etc.) and have instead used the actual historical and cultural contexts to interpret the phenomena described – the concept of solidarity and apolitical politics in the Charter 77 tradition, or the concepts and ideas regarding to the nature of mental illness in the neurobiological German and later Marxist tradition, for example. Being born in Czechoslovakia and having trained there as medical doctor with some time spent in psychiatric hospitals, I have inevitably shared these meanings with my participants. My research could therefore be considered an 'inside-out' anthropology: I did my research in my home country in a familiar environment that I have learned to understand as an experience in a particular historical and cultural context within which social phenomena can be interpreted and endowed with a particular meaning. This 'contextual' difference I attempt to convey in my thesis.

My understanding of the historical and political contexts was strengthened by participation in Marie Curie SocAnth Program focused on post-socialism in Central and Eastern Europe. This three months fellowship in the Anthropology Department of the University College London in 2008 with additional training conferences (Halle, Sibiu, London, Budapest in 2007-2010), EASA conferences in Ljubljana 2008 and Maynooth 2010 – where I co-organised panel on the transformation of psychiatric care in collaboration with Livia Velpřy of CESAMES, Université Paris Descartes – and the Health in Transition Conference in Prague provided me with

additional opportunities to expand my perspective on the issues I studied, discuss my research and learn from other fellows who researched social transformation elsewhere. While doing this research, I was also teaching medical ethics at various universities – Charles University in Prague, Boston University, and Edinburgh University and this provided me with the opportunity to compare this specific experience with those of other countries where mental health care and policy had rather different trajectory – the United Kingdom, the USA, and through Boston also partially in Israel.

## **Ethical Considerations**

This research is classified as level 2 by the Research and Research Ethics Committee, University of Edinburgh, School of Social and Political Studies, and was approved by the University. I also applied for approval by ethics committee in the hospitals where I conducted research – Prague Psychiatric Centre and Kosmonosy Hospital.

In the Prague Psychiatric Center I received written approval for my research on the condition that I obtain written informed consent from all research participants (patients, medical doctors and medical students) and I have observed this condition carefully. All of my data are anonymized and the individual patients are not identifiable on the basis of my description. In Kosmonosy hospital I also applied to the ethics committee and received oral permission from the medical director who did not find approval of the ethical committee necessary given the nature of my research (it was thought that getting permission from patients would only confuse them), my professional background, and the fact that some of the patients were deprived of their legal capacity. However, on all occasions I asked for permission of each research participant, but given these circumstances and the lack of written consent I decided not to use the narratives of individual patients (the only exceptions to this is the introduction and Appendix 2 for which I was given explicit informed consent by the patients who were deemed competent in that regard). Given this methodological limitation I have focused on the institutional and material culture within which the daily life of patients in the hospital occurs. I followed this rule also in my photography documentation. I have depicted ‘empty spaces’ apart from the few instances the photography of individual people was unavoidable as during the art festivals. The photographs allow me to capture the reality of the situations not easily translatable into words and I am using them to complement my written thesis.

An additional ethical dilemma I encountered concerned the inclusion of semi-confidential information that was often discussed by the members of staff in the hospitals which included comments on individual patients but also on various

potentially compromising behaviour and practices of other staff members, such as mistreatment of patients. However illuminating and insightful these comments were to my understanding of the practices of the hospital I did not find it appropriate to include these comments, given the missing (or silent) approval by the ethics committee.

The most significant ethical issue I faced was the double role of being trained as a medical doctor and non-medical researcher. My previous training in medicine and psychiatry gained me unique access to the fields sites and significantly facilitated the trust of all my research informants. My professional background provided me with unusual opportunity to examine the world of psychiatric hospitals and psychiatric care in the Czech Republic from a partial insider perspective, since most of the doctors and staff regarded me as one of them, and were openly discussing their experiences, opinions and doubts. Although I was never actively involved in treating the patients I have benefited greatly from their trust to me as a medical doctor. In my role as a physician-researcher I was treated by patients as someone who appreciates their situation simply by the nature of my profession – although I was not responsible for their care. My fears of being intrusive by observing the daily routines of their life in the hospitals were over and over regarded as unsubstantiated since the patients often considered me an impartial spare ear to listen to their concerns and fears – which they were eager to share with anyone who cared enough to listen to them. (I was reassured when they responded in a similar manner to my colleague at the university who at that time offered me to help deliver some winter clothes collected at the university for patients at Kosmonosy. Since he was also dressed in the white coat the patients immediately gathered around him and overwhelmed him with their life stories.) They appreciated the interest in them as a welcome counterweight the perceived indifference of the outside world – and in some instances also of the lack of time nurses and other staff to talk with them.

I am grateful for this opportunity and hope that my thesis will partially repay their kindness and trust.

Throughout the text I intentionally use long quotations from my informants in order not only to retain the authenticity of their perspective and convey the content but also to capture the tone of their accounts. For the same reason I also use direct quotations rather than reformulations of the texts which I am referring to and through which I am interpreting the findings of my research.

Unless specified otherwise all translations and photographs are mine.

## **PART I**

### **THE SHADOW OF THE PAST**

*What is decisive is the solidarity of human beings with one another;  
state politics at its best can only be its consequence.*

Ladislav Hejdánek, Letters to a Friend, 1977



## Introduction

### The Political Context of the Post-Socialist Transformation

*“It would be very unreasonable to understand the sad legacy of the past forty years as something foreign, something left to us by a far relative. We need to accept this legacy as something that we perpetrated on ourselves. If we accept that we shall understand that it requires a response from all of us. We cannot simply blame it all on previous governments. This would not be the truth and it would weaken the responsibility of each of us, the obligation to act independently, freely, reasonably and swiftly. We should not be led astray: however good government, parliament and president might be they cannot move forward on their own, and it would be profoundly unfair and unrealistic to expect universal redemption from them. Freedom and democracy means participation and therefore responsibility of everyone. If we realize that all the horrors of the past inherited by the newborn Czechoslovakian democracy would cease to seem so horrific and hope would return to our hearts.”*

Václav Havel, 1989<sup>10</sup>

After four decades of communist rule preceded by a decade under the Nazi regime, the early 1990s were for Czechoslovakia a time of great enthusiasm, expectation and hope. In 1989 the longstanding presence of totalitarian regimes in Eastern Europe seemed torn apart in a single storm that swept away the iron curtain dividing Europe into East and West. Because of its geographical position, Czechoslovakia represented a promontory of what was then the Soviet empire into the heart of the continent. Considering itself involuntarily cut off from the flow of history and suspended in time, by 1989 Czechoslovakia was eager to reenter the river of democracy that seemed to sustain and nourish the Western parts of the continent.

As an heir to the Austrian-Hungarian Empire that was erased from the map of Europe in 1918, Czechoslovakia was a late-blooming child of the nationalist movements that demanded the autonomy and self-determination of people united by a common language, territory, and culture. The twenty years following the end of the

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<sup>10</sup> From the speech of Václav Havel following his election as president in December 1989

Great War seemed like a successful attempt to rebuild the world that had disappeared – although on rather shaky foundations. In the First Republic of 1918-1938 Czechoslovakia was a relatively affluent and diverse society governed by the ideals of social democracy. Nevertheless, the Czech historian František Palacký (1798-1876) who prophetically warned that post-Austrian-Hungarian Central Europe would serve as a playing field for the neighbouring empires of Germany and Russia was soon proven correct.

Enduring the war as part of the German protectorate beginning in 1939, and nine years later transferring power into the hands of the Soviets, Czechoslovakia was governed by proxy forms of dictatorship which corroded trust and benevolence among citizens not only in the political sphere but also in the most intimate of relationships.<sup>11</sup> The commonly held historical narrative portrays Czechoslovakia as a nation fallen victim to the regime imposed on it from the outside, and as a result all the traditional structures of social democracy were torn apart (Holý 1993). The fabric of social cohesion was distorted by ideological concerns and political interests and the short wave of democratic renaissance in the mid-1960s – with the programme title *socialism with a human face* – was crushed again under Soviet tanks entering Prague in 1968. Following this short interlude, the country was ‘normalized’ for another twenty years.

In order to allow a new democratic order to take shape after the fall of communist regime in 1989 these disruptions of history had to be emphasized. The notion that the ‘regime’ was imposed upon the nation allowed people to attribute all the undesirable phenomena to the past, and to allow distorted social and political institutions to be discarded and replaced by institutions of the new democratic order. As a result, the ‘Past’ became a symbolic disposal place for anything considered an undesirable burden on the journey towards the ‘Future’ which was understood as a ‘return to Europe’ (Elster and Offe et al. 1998). The sharp contrast between the unwanted past and the desired future facilitated making this narrative plausible and

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<sup>11</sup> For an account of the early years of Soviet rule in Central Europe see Anne Applebaum. *Iron Curtain: The Crushing of Eastern Europe 1944-56*.

convincing, although society itself consisted of the same individuals during the communist times and after the fall of its regime.

However, there was also another current that represented some form of continuity with the opposition to the communist regime: the movement around the Charter 77.<sup>12</sup> Playing a pivotal role in the revolution of 1989 and in the subsequent political transformation of Czechoslovakia, the movement provided the intellectual and ethical foundations of the transformation. The key motives articulated in the document of the Charter, such as the notions of human rights, social solidarity, civil participation, and democracy, gained prominence in the vocabulary of the political discourse in the early 1990s, and Václav Havel, Charter's 77 spokesperson was elected the president of Czechoslovakia in 1989.

Written by several intellectuals in early 1977, this document challenged the communist regime for the failure to implement human rights provision of the Czechoslovak constitution grounded in the treaties signed at the 1975 Helsinki conference.<sup>13</sup> According to the Charter, Czechoslovakia failed to implement these statutes as it continued to persecute citizens that did not comply with the regime. The Charter demanded that the government respect fundamental human rights and freedoms – including freedom of thought, conscience, religion or belief, and cultural and political participation. It was signed by citizens of various backgrounds who described themselves as a *“free, informal and open association of people ... united by the desire, individually or jointly, to insist on the respecting of civil and human rights in our country and throughout the world.”*<sup>14</sup> Their spokespersons were Jan Patočka, a professor of philosophy, Jiří Hájek, a professor of law and a former foreign affairs minister in the 1968 government, and Václav Havel, a playwright. The signatories described themselves not as an opposition political movement but rather as an initiative of people united by their solidarity with those who are denied these rights,

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<sup>12</sup> I refer to Charter 77 rather than to the more commonly used designation of ‘dissent’. Václav Havel especially resisted the term ‘dissent’ as their aim was not direct confrontation with the communist regime but the possibility of creating alternative politics.

<sup>13</sup> Final Act of the 1975 Helsinki Accords, and the United Nations conventions on political, civil, economic and cultural rights.

<sup>14</sup> [http://libpro.cts.cuni.cz/charta/docs/declaration\\_of\\_charter\\_77.pdf](http://libpro.cts.cuni.cz/charta/docs/declaration_of_charter_77.pdf)

and who are concerned about the implementation of ideals they believe in. Following a series of trials and the imprisonment of the signatories of Charter and the persecution of underground musicians and artists – the rock group *The Plastic People of the Universe* among others – Václav Havel with his wife Olga and other signatories of Charter 77 formed the *Committee to Defend the Unjustly Persecuted* in the 1978. Their mission was to help the victims of political persecution by means of legal representation as well as providing material assistance to their families and by informing the domestic and international public about their situation.<sup>15</sup> The respect to human rights in this perspective is primarily the responsibility of others towards those whose are harmed and suffer injustice. Ladislav Hejdínek reflects on this task when he writes:

The aim of Charter 77 is not to gain as many signatures as possible, but to convince the most people that they may and should become free, courageous citizens towards the state, and above all that they may and should treat their fellow citizens as friends and neighbours. In the first place to those fellow citizens who are slandered and defamed, those who are unjustly blamed and denounced, bullied and discriminated, vilified and humiliated. These might be the signatories of Charter 77, but they are outnumbered by others and we need to search for these and not allow them to be alone in their hardships. Human rights are not their ‘natural equipment’ but their are our responsibility, to honor them practically in our acting and deeds, to ensure that in our eyes they are human, they are friends and neighbours, and we would never let them go, even if it might pose a risk to us. What is decisive in human life is what we do for those who hunger and thirst. (Hejdínek 1993 p. 133-134)

The governments response to the formation of this *Committee* was the arrest of six key representatives – including Václav Havel. They were sentenced to two to five years in prison.<sup>16</sup>

During the 1980’ these various protests continued, often as a response to other events in this part of the world – such as the rise of Solidarność in Poland, and election of Mikhail Gorbachev in the USSR. In early 1989 another letter to the government, known as ‘Few Sentences’, was written by people around Charter 77

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<sup>15</sup> Committee for the Defense of the Unjustly Persecuted, <http://www.vons.cz/en>

<sup>16</sup> For a thorough study of this period see Jonathan Bolton’s *Worlds of Dissent: Charter 77, The Plastic People of the Universe, and Czech Culture under Communism*.

and signed by around 40,000 people. This petition reinforced earlier demands on the government to respect human rights, release political prisoners, abandon censorship of the media and the prohibition of public gathering, create conditions and legal framework for independent civil initiatives, and opening a discussion of the political situation – especially the 1950s political trials and the 1968 invasion of Soviet troops. Encouraged by the events in East Germany and the wall of the Berlin wall, series of protests and demonstrations in Prague culminated in November 1989. Originally a gathering of students to commemorate the events of 17. November 1939 this turned into a demonstration and led into confrontation with police. This gave way to uprising and demonstrations in the following days, and grew into a platform gathered around people of Charter 77, known as Civic Forum. They initiated discussion about re-creation of democracy, engaged in negotiations with the communist government, and nominated Václav Havel as the presidential candidate. In December 1989 Havel was elected by parliament with the mission to lead the nation to the first democratic election. The Civic Forum evolved into a political party and won the first elections by a large majority. Their aspiration was to transform not only the social, political and economic institutions but also – and more importantly – the values and moral orientation of the society.

One of the standing issues on the political agenda of the Charter 77 was the respect for human rights. As it was considered that the political and civil rights of citizens were achieved through the overthrow of the communist regime and the emphasis now shifted in focus towards social rights, especially preventing discrimination against previously disadvantaged groups of people and overcoming social exclusion. This emphasis is articulated in Václav Havel's short 1990 New Year Speech to the Nation, where he identified social justice as the most important task of his presidency:

To support anything that would lead to the better social standing of children, the elderly, women, all those who are ill, those subjected to difficult and hard work, members of ethnic minorities and all citizens whose lot is for different reasons worse

than that of others. Better hospitals and better food must not be the privilege of the powerful but they must be offered to those who need them the most.<sup>17</sup>

One of the ways these aims were to be achieved was through the independent initiatives of civil society. In socialist times the state had a monopoly on all forms of social institutions and organisations and independent initiatives were perceived as potentially subversive. This had to change, as these initiatives were now considered key instruments for the transformation of the values and attitudes of society. One of the first and most influential of such independent initiatives was established by Havel's wife Olga in early 1990, *Committee of Good Will*. It had the following mission:

Our desire is that the right for dignified existence is granted also to those who live with physical disabilities or mental illness, those who are destitute, abandoned and old, those with different skin colour or different lifestyle, and those who find themselves in need or affected by insidious illness. Therefore we appeal to people of good will to be willing to help others.<sup>18</sup>

Olga Havlová expanded the scope of her previous initiative – *Committee for the Defense of Unjustly Persecuted* – to demand solidarity with those who are marginalized for their difference and for different reasons often become dependent on others. Among her priorities were the social integration of previously institutionalized people – as was the case with the majority of those suffering from any physical or mental disability – and the defense of the rights of those who due to their long-term conditions have lost their independence. She visited several psychiatric hospitals and offered her support for initiatives aimed to provide for the needs of the patients and enable them to live outside the institutions.

These initiatives utilized some of the motives present in the changing political discourse of the aspiring liberal democracy. The critique of institutions in which most of medical and social care was provided was in terms of them being insensitive to the needs of and often infringing upon the dignity of people whose bonds with their

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<sup>17</sup> [www.vaclavhavel-knihovna.org](http://www.vaclavhavel-knihovna.org)

<sup>18</sup> <http://www.vdv.cz/homepage/>

families and outer world were often torn apart. This motive readily resonated with the critique of the totalitarian regime that infringed upon freedom of the individual and lacked respect to basic human rights, and therefore gained a momentum in the political discourse. There was widespread agreement that these compromised forms of care needed to be discarded and replaced by a more 'humane' arrangements as allowed by the new political circumstances. The discourse opposing totalitarianism and civil society was thus actively promoted by psychiatrists, human rights activists and the international community in order to achieve change in this realm, since it also offered symbolic interpretation of material culture and professional practices associated with psychiatry: the large psychiatric institutions, where majority of care is provided, became symbols of the restrictive totalitarian power, the cage beds used for agitated patients the unacceptable forms of restraint to the liberty of the individual. On the other hand, community care was considered to represent a modern approach more appropriate for the new era of civil democratic society with ambitions of social inclusion and overcoming of the stigma and isolation that psychiatric patients previously experienced.

In order to explore how this historical and political context influenced the area of psychiatric care I shall turn to the retrospective accounts of psychiatrists and others who attempted to reform the system providing for the care of the mentally ill. In documenting the roles of individuals who were the initiators of this project I will also examine the intellectual context and the hopes and expectations that guided their actions. In the area of psychiatry there were already several unofficial initiatives in place in the 1980s which saw the change of the regime as an opportunity to transform the way of care is provided for those with severe mental illness. The priorities for transformation were providing psychosocial support to patients and their families in the community as an alternative to the institutional care, respect to the rights of patients and improving the conditions and quality of care in the hospitals. In the following chapters I shall describe the history of these initiatives, tracing the ideals that guided them and examining the changing political discourse

and also offer an interpretation of these events through the lens of the motives introduced by the initiatives inspired by Charter 77, namely the notion of human rights as an expression of social solidarity, the practice of apolitical politics, and the concept of Europe that represented specific moral values and aspirations of the early days of post-socialist Czechoslovakia.



## Chapter 1

### Solidarity of the Shaken: The Legacy of Charter 77

#### The Origins of the Initiative for ‘Humanization of Psychiatry’

*“In the era of the totalitarian regime mental health was a neglected area of life, where manifestation of general demoralization, disrespect to the person and her rights, ideological and social prejudices, professional passivity and extinction of social responsibility were enormous. Despite the circumstances, several independent minded professionals (psychiatrists, psychologists and psychotherapists) attempted to gain space for the change of conditions and, in the constant battle with authorities as well as with the prejudices of the public, inspired users and volunteers to action. These attempts in recent years opened the public discussion of psychiatry and modern ways of mental health care and brought into life the idea of the Society for Mental Health which the peaceful revolution in our country enabled us to realize.”*

Preamble, Czech Association for Mental Health, 1990<sup>19</sup>

These are the opening sentences of the manifesto of the Czech Association for Mental Health established in January 1990 by a group of psychiatric patients, psychiatrists, and members of the interested public. In the first paragraph of their program statement they express their support for the Civic Forum, the key political platform arising from the 1989 revolution led by Václav Havel who was elected president few days earlier. In this text they express the hope that democracy and social justice will improve conditions for people living with mental illness who were previously condemned to life in large institution without adequate attention and care. This was a first initiative that opened up discussion on the state of mental health care and around which further debates around transformation of psychiatry evolved.

This manifesto was written by several people who worked in the area of mental health care and knew each other as professionals and friends. The kernel of this group was organised around a community center for patients with psychotic

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<sup>19</sup> Mosty, No 4. p.3

conditions established as ‘a club’ in Prague in 1983. This club was founded by three individuals as a response to their personal or professional encounter with psychotic illness. Kamil Kalina, a psychiatrist, Želimir Procházka, president of the Association for the Support of Mentally Handicapped,<sup>20</sup> and Jolana Poláková, a philosopher with interest in phenomenology and psychotherapy, who for political reasons was forbidden to practice her profession.



Inner courtyard, Kosmonosy hospital, 2010

All three of them were motivated for their work by their personal encounters with someone suffering from mental illness. For Dr. Kalina, this was his professional encounters with his patients that also inspired him to open one of the first day clinic for psychotic patients in Prague few years earlier. For Ing. Procházka, this was the experience of psychotic illness by his daughter, and Dr. Poláková recalls her own interests in founding the community center:

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<sup>20</sup> Organisation established in 1969, <http://www.spmpr.cz/cs/uvod/z-historie-spmpr/>

“My own motivation originated from a visit to the psychiatric hospital in Kosmonosy where I was invited in late 1970s by my friend, a recent graduate of medical school, who wanted to show me that place as something strangely interesting. What was appalling to me was the way in which this woman – whom I knew for about ten years and who seemed to me rather normal in interpersonal relationships – suddenly changed when dealing with psychiatric patients: as if they were not human, but rather some bizarre insects. I realized that this attitude (which she invoked as generally reputable) can hurt more than the mental illness itself, and that these abandoned, isolated, powerless, frightened and humiliated people need some help. ... In the 1980s the communists did not allow me to work in my profession, and so in addition to my day job in a publishing house I assumed volunteer activities for which I felt deeply motivated. ... I learned about the existence of the Association for the Support of Mentally Handicapped and approached Mr Procházka with a question whether they have any activities with psychiatric patients, for which I would like to create a club. He happily referred me to Dr. Kalina, and that is how the club on the premises of the Association came into being, under the auspices of Kalina’s sanatorium. Without this institutional entrenchment this initiative would in the times of the paranoid regime be considered an underground or actually anti-state activity.”<sup>21</sup>

From 1988 onwards this Club was publishing a journal called ‘Mosty’ – ‘Bridges’. It was filled with essays, reflections and pieces of art of their members, both patients and professionals – not unlike samizdat literature common at that time. One can trace individual stories throughout the volumes of the journal and observe the development of ideas and activities. Each volume also includes essays by various philosophers and psychologists with a very strong existential undertone. This journal represents a document of the early initiatives of that time: *“Humanization of psychiatry, the meaning of life, friendship, art of living, creative self-realization – these were the topics of our interests.”* (Mosty 3, Introduction) It is especially interesting to follow the impact of the 1989 revolution on the pieces published here.

Dr. Jolana Poláková continues her account of this initiative:

“In the beginning the club served the clients of Kalina’s sanatorium (without this institutional support this would be considered as underground and anti-state activity in the circumstances of that paranoid regime) but soon their friends – and friends of their friends – started to attend, and in addition some of my friends joined in. In other words, the non-patient interested public attended and subsequently also professional psychiatrists who often hardly recognized their own patients because they behaved

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<sup>21</sup> Dr. Jolana Poláková, email communication January/April 2010

rather differently in the club than how they were used to know them from their offices and hospitals. That is how this quite productive tri-parity evolved. Participating in common activities – various cultural, educational or just entertaining programmes and discussions – organized by members of all three backgrounds, they were getting to know each other on a common, human level, and as a result common prejudices and barriers slowly disappeared and new ways of communication were created. For most of the participants – from all three backgrounds – this experience changed their attitudes and relationships to the ‘patients’ or ‘lunatics’ as well as to the ‘white coats’ and ‘the normal’. These activities were then guided by nothing else than need for human relationships and creativity of its members who found this as a response to their interests. The club members also somehow overcame the reality that some of them (as far as I remember, AH, JJ, VB, VP and SM) were unexpectedly dying while hospitalized in the psychiatric hospital. The most difficult tragedy was the death of SM of which you can read in *Mosty* No. 9.”<sup>22</sup>

The experience of witnessing a life devastated by mental illness and the conditions of psychiatric institutions was a common motive for personal initiative among many of my informants working in psychiatry, both professionals and volunteers. Many of them recalled very personal stories on their way to psychiatry: the lives of friends or family members devastated by the illness or the encounter with ‘inhumane’ conditions of the institutions they worked in. For many, the voluntary participation in these initiatives and even the choice of the profession was a response to the suffering of others. This is true also for another psychiatrist involved in the Society, Dr. Martin Jarolímek, for whom the motivation for becoming a psychiatrist also comes from a very personal experience. His older brother had to leave his medical studies because of the onset of schizophrenia and he decided to take on his path to become a medical doctor. His first position was in the Kosmonosy hospital – the same hospital about which Dr. Poláková was writing, in which I later conducted my research. Similarly, he was horrified by the conditions of life of the patients as well as the harsh behaviour of some of the staff towards patients. Dr. Jarolímek’s own perspective on psychiatry subsequently changed significantly because of a friendship he developed with one of his patients there. He recalls this experience as crucial for his insight and understanding of psychotic illness:

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<sup>22</sup> Dr. Jolana Poláková, email communication, January/April 2010

“I first worked for two years in a psychiatric hospital, in one of the worst madhouses ever, which is the Kosmonosy hospital. I am not sure why it was so appalling there, whether it can be attributed to its location in former monastery. However, in that time there was a truly terrifying director who definitely contributed to that and several rather eccentric psychiatrists. Despite all of that it was a very good experience for me... I met there one patient, Mirek Pátek, who taught me the most about life – and what psychosis means. I met him on the ward where he was hospitalized for ten years, and most of these ten years he spent in the cage bed... And I, a young and enthusiastic psychiatrist in making decided that I will rescue him from this cage bed, that I will heal him. Mirek was overcome by psychotic attacks mostly at night to which the nursing staff responded by injection and a cage bed, they would not even bother to call the physician on call. I insisted that they call me whenever this attack comes – in order to learn what these attacks are about. The nurses of course considered me mad to ask for this because that would also disturb their half-sleep at nights. However they had to accept it and so they would call me and I would come to see Mirek. When this attack came over him they still would put him in the cage bed and I would sit by the cage and put my hand through the net and hold his hand and use what I have learned in hypnosis, the suggestive influence to calm the person. Sometimes I would sing a song or tell a fairytale – which he of course could not apprehend since he was in this extremely confused state, but still it might slowly calm him down. It was a rather long process lasting at least a year but in the course of that year I achieved first that it was not necessary to put him into the cage bed, then he was allowed to go for a walk within the premises of the hospital, then he started to take care of the plants and greens – both in the ward and outside in the garden, and then under my supervision he was allowed to go for a walk outside of the hospital. His parents had renounced him and did not want to have anything to do with him, and so it was me who took him for the first time after eleven years out of the hospital. However, he could not cope with being out of the hospital finally and when we were going over the bridge he decided to jump down into the river. I had to hold him firmly and fortunately a car was just passing by and took us back to the hospital, which for him meant going back to his cage... It was not for too long though... And then I had even more crazy idea – I invited him to move in into my room. I was also living in the hospital at that time and we had very large rooms there. I do not like these large empty spaces. There were several large wardrobes and I used them to create two separate ‘cells’ within that room, one for Mirek, one for me. We lived there and we would go for walks in the hills behind the hospital. Mirek never talked much, but he was writing poems, drawing pictures... He was a beautiful naive pure person. Roughly my age, he was Mirek Pátek [Friday] and he called me Robinson – we were kindreds on this desert island the fate has thrown us onto. And then I took him to the nearby town and taught him to use the public transport, he has never done that before, and then I found a job for him in a nearby factory, for four hours a day, and so he started working there and was able to commute every day. But the God decided to punish Mirek with Hodgkin... Mirek died in Bulovka hospital and again I was holding his hand... They operated him but he died anyway... And it is all

rather curious, the other psychiatrist there, Rudolf Kohn, whom I was quite close with, with whom we would go for night hikes and make ourselves a shanty on the hill and stay there overnight sometimes, is now dying of cancer, too...”<sup>23</sup>

This experience has significantly influenced Dr. Martin Jarolímek’s career. He soon left the hospital to establish day sanatorium for patients suffering from psychosis in 1986 in Prague and in the 1990s founded a whole series of organisations providing support patients and their families.<sup>24</sup> The inspiration for these initiatives was a day sanatorium in Kosmonosy hospital run by Darja Kocábová. He recalls: “Actually there was one positive thing at that time in Kosmonosy, a day sanatorium run by Darja Kocábová, a psychologist and a wife of Fred Kocáb, the protestant minister and mother of Michal Kocáb<sup>25</sup>, and thanks to her I learned to work with psychotic patients. She is amazing and we are still friends with Michal and with Darja. Fred also negotiated internship in Taizé in France with Pater Roger and I spent a month there in his community and had a chance to talk with him for an hour every day. It is a curious coincidence that he was later murdered by a psychotic patient...”<sup>26</sup>

Psychotherapy was an area in which the people around Charter 77 and those around psychiatry shared a common ground and where these two circles merged socially – although underground. During communism psychotherapy was relegated to the ‘unofficial sphere’ with the Czechoslovakian Psychoanalytic Association banned in 1950. Psychology as such was considered a ‘bourgeois ideology’ and although was still taught at universities, the numbers of students allowed to study this programme were very low with their roles limited to work in clinical psychology, education and occupational psychology. However, psychotherapy was practiced, discussed and taught only semi-officially – in a manner similar to that of the ‘underground university’ organised by Jan Patočka and his students in their homes. Their approach was eclectic rather than limited to any specific school of thought, although often it had an existential tone. The emphasis in psychotherapy was

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<sup>23</sup> Dr. Martin Jarolímek, interview January 2010

<sup>24</sup> Klinika nad Ondřejovem, Green Doors, Café na půli cesty, Czech Association for Mental Health, Esprit journal etc.

<sup>25</sup> Composer, rock musician and political activists, one of the initiators of Civic Forum in 1989, Minister for Human Rights and Minorities in 2009-2010

<sup>26</sup> Taizé is an ecumenical community in France. [http://www.taize.fr/en\\_rubrique2602.html](http://www.taize.fr/en_rubrique2602.html)

primarily on the relationship of the therapist and the patient – the traces of this approach were tangible even during my fieldwork: seminars for medical students on psychotherapy were entitled ‘the therapeutic relationship’ and the conference of social psychiatry I attended was devoted to the theme ‘mental illness and relationships’.

These social worlds of the underground merged where the critical as well as creative thinking was nurtured. There was another aspect that facilitated these social encounters: the worlds of the psychiatric hospitals – remote and surrounded by walls – often provided a refuge to the people whose orientations did not necessarily fit with the regime and who were conveniently out of sight there. The Research Institute for Psychiatry established in 1961 (currently the Prague Psychiatric Centre) was one of the more liberal institutions, and several post-1989 politicians and diplomats worked in the 1960s and 1970s. At the celebration of the anniversary of its establishment that I attended its current director Professor Cyril Höschl commented on the ‘high concentration of individuals dissenting with the regime and very low concentration of communists’. This allowed a certain freedom and created rather specific institutional culture where samizdat literature was circulated, and surrealist art and psychoanalysis discussed – in addition to neurobiology and biochemistry. Cyril Höschl recounts:

“I was very impressed by the psychotherapy practiced here. The director of the neurosis ward, Věra Fischelová, until nowadays a practicing psychoanalyst, was leading group therapies together with Ivan Nádvorník. We practiced eclectic psychotherapy influenced by the Palo Alto school and complemented it with reading of Sigmund Freud, Frieda Fromm-Reichmann a Stanislav Kratochvíl. Everywhere else the storm of ‘normalization’ was taking its toll but in this institution we had a lot of freedom – with liberal directors, unruly patients, open-minded colleagues, and very little administrative tasks. At that time I could only guess that one of my colleagues was trained by Dr. Kučera, founder of Czech psychoanalytic school. That would account for illegal and subversive activity and nobody would dare to mention that aloud.”<sup>27</sup>

The time of relative liberation and revival of international contacts in mid-1960s opened up the opportunities for psychotherapy. One of the few

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<sup>27</sup> Professor Cyril Höschl, 23.10.2006

institutions providing psychotherapeutic training was SUR Institute established in 1967 and named after its founders – Jaroslav Skála, Eduard Urban and Jaromír Rubeš. This institute followed an eclectic approach to psychotherapy with an emphasis on self-knowledge and reflective experience, combining insights from traditions whose intellectual orientations are often considered conflicting or even irreconcilable. The institute also provided space for developing new ideas and practices in this area of psychotherapy in psychiatry, and tended to attract people with similar interests, attitudes and beliefs. It became a seedbed and network for people who were critical of the regime and facilitated exchange of their insights and initiatives, and represented the space where the world of ‘underground’ or unofficial culture met with the world of psychiatry. Dr. Martin Jarolímek recounts:

“The dissent influenced significantly the development of psychotherapy especially in the psychodynamic tradition. ‘Few Sentences’<sup>28</sup> originated and was spreading from here. We attended unofficial or even illegal lectures. Václav Havel and his brother Ivan, different psychiatrists and psychotherapists and artists gathered there. We also organised a summer camp which is in existence until now, every summer we spent two weeks together nearby a small village of Hornosín. We used to gather there – both the dissident part and the psychotherapeutic part – although actually we were all mixed together. There I met my best friend, Janko Langoš, who later became a federal minister of the interior, Václav Havel – somewhere I have a picture of Václav on a barrow carried by my son. This initiative grew and included more and more people – many of which later played a role in politics. They continued to come there even after they become officials in the government – the villagers then made a proper road to this camp and until today they have their seats reserved in the local pub – Langoš, Ruml, Havel... Every night we made a fire and someone would give a talk about what interested them, Kamil Kalina for example came with the future conception of healthcare and the reform of psychiatry, we all imagined on how to do things after the Bolshevik gets to hell... We all hoped for freedom and were planning on how to do things better then.”<sup>29</sup>

Given the political circumstances and the impossibility of official recognition and support of these various initiatives these psychiatrists first tried to change the

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<sup>28</sup> ‘Few sentences’ was a petition authored in early 1989 by the Charter 77 and signed by around 40,000 people. This petition reinforced earlier demands on the government to respect human rights, release political prisoners, abandon censorship of media and the prohibition of public gathering, create conditions and legal framework for independent civil initiatives, and opening a discussion of the political situation – especially the 1950s political trials, the 1968 invasion of Soviet troops etc.

<sup>29</sup> Dr. Martin Jarolímek, interview January 2010



conditions for psychiatric patients themselves. In addition to these various day sanatoria and clubs, those working in the psychiatric hospitals were hoping to improve the situations of their patients and change practices of the institutions that they considered unacceptable. Unlike in other countries where the changes were influenced by the 'anti-psychiatry' movement it was mostly the psychiatrists who had immediate experience within the hospitals who were urged to take up the challenge. The fall of the regime seem to provide the occasion to change the world of psychiatric hospitals. Guided by genuine concern and respect for their patients they took the initiative to create more pleasant and supportive environment for patient that would facilitate their recovery. The psychiatrists I interviewed were realistic and acknowledged that psychiatric hospitals are difficult places by the very nature of conditions of patients they care for and this exerts influence on the staff as well. This is true irrespectively of the political system to which the conditions were often attributed.

As an illustration of this I introduce an account by Dr. David Holub – one of the younger generation of physicians whose graduation coincided with the change of the political regime.

“After graduation I started working part time in Beřkovice hospital and spent there three years. It was a classical example of hospital after the socialist normalization – four physicians attending to 600 patients, desperate lack of resources. They recruited young physicians to help and since we were quite inexperienced it was rather improvisatory. Beřkovice hospital serves as a refuge of last resort, it provides a secure space for treatment and offers support to people who repeatedly fail, who do not manage to return into their communities. Unfortunately the price is the loss of autonomy and increasing dependence of patients on the system. The forms of institutional care do not only reflect the attitudes within society, inside structures emerge with their own dynamics which are product of interactions of people who have their own inner world – extremely complex and difficult inner world, which then also affects the interactions of the staff. It makes a huge difference when you do not treat people as objects, or second rate citizens, but alleviate their suffering and provide support for them.”<sup>30</sup>

Dr. David Holub later became director of the psychiatric hospital in Ostrov and incorporated psychotherapeutic principles of care with a great emphasis on the

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<sup>30</sup> Dr. David Holub, interview January 2007

training and support of the staff working there. He also collaborated with various initiatives that provide alternatives to the miserable conditions of the large hospitals in the community.



Chronic ward for male patients, Kosmonosy hospital, 2007

The motivation to work in this area, as noticeable in the narratives of my informants, was grounded on a shared experience of fragility and the finitude of human existence as well as of the vulnerability of the structures of the social world – an experience of what Karl Jaspers, German psychiatrist and philosopher, referred to as ‘limit situations’ (*Grenzsituation*; Jaspers 1919).

Jaspers’s concept of limit situations refers to the experience of limits to our existence, of being exposed to or confronted with the finitude of our existence in suffering and death, an overwhelming experience of dread, anxiety or guilt. In his later work Karl Jaspers also refers to the experience of *Geschichtlichkeit* – being torn

by historical forces beyond one's control – reflecting on the experience of the totalitarian regimes in Germany and Russia (Jaspers 1932). These situations – illness as well as political oppression – share similar aspects: they are unconditioned, resist our deliberate will, they 'come upon us'. This allows Jaspers to frame even the experience of psychosis as 'existential' rather than medical condition – an inherent possibility of human life.

The experience of mental illness that shatters the life world and challenges the taken-for-granted structures of the world resonates with the experience of life deformed by political forces of the totalitarian regime. This experience of 'shaken-ness' then becomes the source of the response to the 'shaken-ness' of the other – creating a community of those who are aware and take seriously this experience and its implications. These moments can be read as 'ciphers of transcendence' as they allude to something that transcends the definitiveness of human life and opens up the ethical space of responsibility. This is how the solidarity of the shaken is awakened (Patočka 1996).

There was nothing primarily political about these initiatives, but nevertheless, they embodied what Václav Havel called the 'pre-political' in his essay on the meaning of Charter 77:

"It would be a great mistake to underestimate the invisible processes in the soul of the society and the specific political meaning the moral and existential acts gain in certain circumstances; these are pre-political acts in circumstances where politics is de facto abrogated." (Havel 1986)

These 'pre-political acts' then represent the essence of what has the potential to transform the social order. The grounding of the political in the 'moral and existential acts' is then a very significant point of departure for social transformation. This conception of politics is grounded in the experience of 'shaken-ness', the confrontation with the inherent fragility of human existence and the ethical responsibility that arises from this experience – solidarity. This 'existential conception of politics' was most notably formulated in the *Heretical essays in the Philosophy of History* by Jan Patočka – a professor of Charles University and one of the initiators of Charter 77 whose untimely death following hours of interrogation by

secret police on January 13, 1977 charged this document with insistent moral appeal.<sup>31</sup>

In the final ‘heretical’ essay Patočka portrays the twentieth century as a war, a state to which there is no outside, a force that destructs all life, and leaves people ‘*shaken in their faith in the day, in life, and in peace*’ (Patočka 1996; p. 134). He suggests that this absolute state of war can be overcome by the solidarity of those who are aware and acknowledge the inherent contingency of life, the vulnerability and finitude, the possibility of ‘shipwrecking’. The awareness of the shared human condition is thus what grounds solidarity towards others and the experience of being shaken thus has an ethical implication: once experienced there is a responsibility for sustaining life and peace – there is a responsibility for others. This is what constitutes ‘living in truth’: acknowledging our own limitations, taking seriously the finitude of our existence and accepting the responsibility for others – which is also what renders life meaningful. This solidarity then represents the origin and a foundation for the political project – the existential conception of politics of Charter 77.

In the 1978 essay *The Power of the Powerless* Václav Havel ties these motives together when he refers to post-democratic structures as the foundation of the strive for a more just society. He concludes his essay:

“Does not this vision of ‘post-democratic’ structures in some ways remind one of the ‘dissident’ groups or some of the independent citizens’ initiatives as we already know them from our own surroundings? Do not these small communities, bound together by thousands of shared tribulations, give rise to some of those special humanly meaningful political relationships and ties that we have been talking about? Are not these communities motivated mainly by a common belief in the profound significance of what they are doing since they have no chance of direct, external success joined together by precisely the kind of atmosphere in which the formalized and ritualized ties common in the official structures are supplanted by a living sense of solidarity and fraternity? Do not these ‘post-democratic’ relationships of immediate personal trust and the informal rights of individuals based on them come out of the background of all those commonly shared difficulties? Do not these groups emerge, live, and disappear under pressure from concrete and authentic needs,

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<sup>31</sup> Patočka studied with Edmund Husserl and Martin Heidegger and was profoundly influenced by the motives of phenomenological and existential philosophy. Banned from university teaching for most of his career, he organized an ‘underground university’, a seedbed for Prague intellectuals who later came to play prominent roles in political life in the early 1990s.

unburdened by the ballast of hollow traditions? Is not their attempt to create an articulate form of living within the truth and to renew the feeling of higher responsibility in an apathetic society really a sign of some kind of rudimentary moral reconstitution? In other words, are not these informed, non-bureaucratic, dynamic, and open communities that comprise the ‘parallel polis’ a kind of rudimentary prefiguration, a symbolic model of those more meaningful ‘post-democratic’ political structures that might become the foundation of a better society?

I know from thousands of personal experiences how the mere circumstance of having signed Charter 77 has immediately created a deeper and more open relationship and evoked sudden and powerful feelings of genuine community among people who were all but strangers before. This kind of thing happens only rarely, if at all, even among people who have worked together for long periods in some apathetic official structure. It is as though the mere awareness and acceptance of a common task and a shared experience were enough to transform people and the climate of their lives, as though it gave their public work a more human dimension than is seldom found elsewhere.” (Havel 1978)

For Havel, post-democratic politics is an arena of the pre-political, on-the-ground activities that grow from the exigency of civil responsibility – as “*one of the ways to search and endow life with meaning, how to protect life and serve the truth*” (Havel 1989, p. 57). It is again this motive of the solidarity which he considered to be the origin of any meaningful politics.

One of the most significant aspects of the ‘existentialist conception of politics’ is the conviction that it is ultimately ethics that grounds politics. In the 1977 essay *On the Obligation of Defense Against Injustice* Jan Patočka clarifies this point. He is convinced that states and any political formations are subject to the sovereignty of unconditional moral demand, and various social practices and legal norms are established in the service of this higher, ethical demand. This demand is binding and becomes a source of responsibility that people have towards one another. He develops the Kantian idea that all moral duties are anchored in what can be understood as the obligation of the person toward themselves. This obligation also carries with it the imperative to protect oneself against any injustice suffered which extends to the duty to defend others against injustice they suffer and make their situation known. Patočka continues to interpret the Charter 77 as an act derived from

this obligation – from the ethical demand that is above politics and which ground political rights:

“Therefore, no one who truly suffers injustice should not feel abandoned, left at the mercy of overwhelming circumstances, as long as they remain faithful to the obligation of defending themselves – the obligation that is at the same time his obligation towards society they are part of. The purpose of the Charter 77 is therefore the spontaneous and genuine solidarity of all who understood the importance of the ethical consideration for the life of the society.” (Patočka 1990)

The obligation towards those who suffer injustice is the foundation of just society – the political is grounded in the ethical. The political philosopher Aviezer Tucker comments on this:

“Only during rare periods of historical crisis can we observe the merging of philosophy and politics, when politics requires the intellectual resources of the philosophical pre-political and pressing political problems force philosophy to attempt to find practical yet moral answers to these problems. During such periods of crisis, philosophy and politics tend to converge. Czechoslovakia’s Charter 77 dissent movement was a rare historical moment when philosophy and politics united.” (Tucker 2000, p. 1-2)

Although the Charter 77 was possibly the most significant of the underground movements in communist Czechoslovakia, there were other initiatives that emerged in late socialism that were breathing the same air. Usually, they arose as a response to the dire state of particular area of social life and by taking on personal initiative they were hoping to transform an area in which they became involved in. The initiatives around psychiatry where people who were professionally involved and as an act of solidarity were attempting to change the conditions for their patient is one example of these activities, of ‘demanding justice’ for those who are – by the nature of their condition – the least likely to demand justice for themselves. In these cases it was the psychiatrists and others involved in this area who took on the responsibility and although their political leverage proved not sufficient to significantly alter the system their response provided the direction for the attempted transformation.



## Islands of Totality: Psychiatric Hospitals as Remnants of the Past



Bohnice psychiatric hospital, aerial view, 1990s (archive)

*“The psychiatric hospital is surrounded by a monumental walls that serve well their purpose: to separate the two worlds. As if their world was beyond the borders and beyond the horizon of our world – nevertheless, even that world is a human world, however engulfed by the immense concentration of loneliness, harshness, and desperation.*

*This reminds us how wrecked, indifferent, and selfish is the society we live in.”*

B.K.<sup>32</sup>

In December 1989 – just a few days after the demonstrations erupted in the centre of Prague as the Velvet Revolution – the psychiatrists working in Bohnice, the largest psychiatric hospital in Prague, gathered and established their own local organization of the Civic Forum, the political platform around Charter 77 people led by Václav Havel. One of their first activities was an audit on the misuse of

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<sup>32</sup> B.K. in *Mosty* No 6, p.3

psychiatry for political purposes by the communist regime. They also opened a debate on the transformation of psychiatric care and the possibility of comprehensive mental health law that would guarantee more respectful treatment of their patients and improve the quality of care. They also nominated one of their members, Zdeněk Bašný, as a candidate for directorship of the hospital.<sup>33</sup> The enthusiasm of these early days gave rise to various independent initiatives that aimed to transform the culture of large psychiatric institutions which became perceived as symbols of the totalitarian regime associated with the repressive power of the state – and therefore in need of thorough reform. The psychiatrists were hoping to provide alternative to these institutions by establishing services that would allow the patients to return to the communities they were living in. Very soon, the project of transformation was framed in terms of ‘humanization of psychiatry’. The task these psychiatrists have given themselves was threefold: improve the conditions in the psychiatric hospitals; create alternatives to the hospitals in form of intermediary community care; and work towards comprehensive mental health policy and mental health law that would demand respect to the rights and needs of the patients and guarantee high quality and continuity of care. The urgency felt in that time is tangible in the deadlines that those involved in the project gave themselves: comprehensive mental health law and the proposal of complex transformation of psychiatry to be presented to the parliament before the end of 1991.

Although the healthcare system in general was considered in need of reform in psychiatry this was felt with greater urgency. One of the first means considered for this purpose was introduction of a different legal regime governing psychiatric care. In an article from early 1991 Petr Krejčí of the Czech Society for Mental Health provides justification for this approach:

“Healthcare specialties differ significantly in the extent of their backwardness, and areas on the bottom of the list are those where the citizens are the least likely to defend themselves: long term care for the disabled, the elderly, and the psychiatric patients. There the reform – or rather a revolution – needs to be the most radical. We

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<sup>33</sup> Directors of hospitals are appointed by the Ministry of Health.



must create a framework for the healthcare system where the citizen is respected as a free and dignified human being, and not a mere object of healthcare. A human being that is not reduced to appendicitis or manic-depressive psychosis but a person who participates on the care and shares responsibility for their health. Psychiatric patients have rather specific standing among other sick. They are the least tolerated in their environment, while other citizens tolerate and even silently approve of the violence committed towards them – more than they would do with any other category of ill people. Mentally ill patients are in need of protection of their human rights – especially the right to be treated as a human being endowed with inalienable dignity – also while they are hospitalized. If we look inside the psychiatric hospitals we are assured that often this is not the case – these hospitals still are islands of totality. The new legal framework for psychiatric treatment should also guarantee comprehensive prevention and rehabilitation. It should not be done in a paternalistic way but rather by creating space for initiatives of individuals and communities that aim to protect freedom and dignity of those who are unable to defend themselves.”<sup>34</sup>

There are several noteworthy motives in this contribution, the major being the shift from the medical to legal context. Patients are considered primarily as citizens holding unalienable rights, and the role of the law is their protection. If the provision of adequate care for vulnerable citizens is part of the social contract implicit in the welfare state, the state is breaching this social contract by not responding to their needs and not treating them with dignity they deserve as human beings. There is also Patočka’s motive of the obligation to defend against injustice – which in this case is interpreted as the obligation of others who witness the injustice perpetrated on those who are not able to defend themselves to protect their freedom and dignity. The indifference, or silent toleration, of ‘other citizens’ amount to being accomplice on these injustices. It is therefore not only the task for medical profession from which the initiative comes from but for the society at large.

The psychiatric hospitals in the communist era were hermetically closed worlds of their own, surrounded by walls and far enough from the public spaces, as many of my informants recounted. In many cases permission was needed to enter even to visit a friend or family member which was nevertheless only possible during the visiting hours: mostly two hours twice a week. Most people were only vaguely

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<sup>34</sup> Petr Krejčí, Why do we work on a mental health law? *Mosty* No 6, 1991/1, p. 5-6

aware of the existence of such institutions which were often built far from town and settlements – although the names of the institutions are well known and their local names are part of the common cultural vocabulary as spaces of madness.<sup>35</sup> Some of the patients and family members I talked with confessed that the whole world of psychiatry was completely invisible to them before the illness erupted in their lives. Only then they started to realize how desperate is the situation in the hospitals is and how essential is it to have more support for these people in the community. The contrast between the world outside and inside the hospital also became more striking throughout the time as the standard of living increased over the past twenty years – as did the life expectations of people within relatively affluent society – while the hospitals remained stuck in the past.

One aspect of the socialist ideology was inclusiveness of the state system of care where people with any handicaps are taken care of in special institutions. Families were encouraged to give up their disabled children to the care of the state who was considered better suited to provide for their needs. The adverse effect of this policy was that people very rarely encountered someone with disabilities or handicaps – which contributed to the high level of stigma of disability and illness. Moreover, the ideological pride of socialist society was the improvement of the health of the population – a framework in which, as a result, illness was considered an embarrassment or even failure of the system. This was then another convenient reason for institutionalization, to hide the disability from the views of public.<sup>36</sup> The closed character of these institutions then protected the state from any potential criticism concerning the conditions in which people lived there.

Although it might seem paradoxical that the socialist system which prided itself on the provision of equal treatment and comprehensive health and social care now became the object of deep discontent and harsh criticism, it was actually the *degeneration* of the system that was blamed for the failure to provide adequate care

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<sup>35</sup> Bohnice, Beřkovic, Kosmonosy etc. – analogical to *Bedlam* in the UK English.

<sup>36</sup> Notorious in this respect was the annual closure or ‘evacuation’ of institution for physically handicapped children, Jedličkův ůstav, located close to the Congress Hall, during the annual convention of the communist party to protect the delegates from seeing physical deformities.

while respecting human dignity. The paternalism exercised through state institutions became restrictive and even destructive force since the individual disappeared in the mass of the people – passive subjects of the regime. In a 1991 article published in *Mosty* Petr Krejčí writes:

“We live in a strange time. The old political and economical system has fallen apart and the new one has not come yet. In retrospect many things that we perceived as imperfect but thought that with a little of good will be repaired and refined now seem as something entirely absurd that we must leave behind because it will never be functional again. Among these absurd things belongs the system of healthcare and healthcare institutions. For forty years we have nurtured by the idea of being provided free healthcare system and that it is the obligation of the state to provide us with health. This was not true in the first place – we always paid for the healthcare through taxation, only we were not aware how much of this taxation actually provided for healthcare. Also, this forced us in the position of child that is provided for by the kind paternalistic state. And so the healthcare that was supposed to be a service to the citizen transformed into paternalistic organisation that treated sick people as incapacitated and legally incapable. The sick became passive elements dragged by healthcare institutions, scolded by anyone, and they were constantly reminded they are not in the position to demand anything when your care is provided from the kindness of the state, for free.”<sup>37</sup>

The regret that the individual is lost in the complex machine of the state – and in the case of ill people considered as damaged, useless and discarded components – needs to make space for a different approach based on the respect to the individual and their needs. Again, this is a motive of Charter 77 known from Havel’s writings that resonated throughout the discussions on the future of psychiatry and healthcare.

The psychiatrists and other professionals working in this area also immediately established contacts with the international community in Western Europe – The Netherlands, United Kingdom, France, as well as United States. Western countries were considered modern and progressive in their practices since many of them have passed through the de-institutionalization phase and introduction of community care in preceding decades, and several of them had comprehensive mental health law. These contacts were established through academic collaboration although many were also results of reconnecting with former colleagues who

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<sup>37</sup> Petr Krejčí, *Why do we work on a mental health law?* *Mosty* No 6, 1991/1, p. 5-6

emigrated, and consisted of visits, internships and joint conferences. The already mentioned Society for Mental Health Care joined the World Federation for Mental Health in 1990 following the visit of its former president Edith Morgan from the United Kingdom.<sup>38</sup> At this stage the funding of many of these initiatives came from foreign governments as well as from the Open Society Fund – an organisation involved in the post-socialist transformation in Central and Eastern Europe that promoted the model of non-governmental organisations as a way of establishing civil society.

There were different reasons for looking for inspiration towards the West. In the early 1990s there was a widespread feeling that we have missed on the progress that shaped Europe on the other side of the iron curtain. It was the feeling that Havel captured in his phrase ‘time of the timeless’ – referring to the experience of late socialism that aimed to conserve present in the past, eradicating any possibility for change, and ending history (Havel 1989). Moreover, the Western experience of 1960s in which the traditional social order was subjected to critique did not happen to the same extent in Eastern Europe. Although there was a short period of political liberation, known as the Prague Spring, it was forcefully suppressed in Czechoslovakia by invasion of the Soviet army in 1968 and forced restoration of the order known as ‘normalization’. These accumulated feelings of discontent therefore came into full blown eruption only in 1989 accompanied by a very intense desire to ‘catch-up’ with the West and reintegrate into Europe. Dr. Jan Pfeiffer comments on this experience of marginality and missing out:

“We have always been the periphery of Europe, historically, even Austro-Hungarian Empire was rather backward and underdeveloped country, militant, peasant... But this goes beyond that – despite what we have learned about the Hussites and the early reformation at school – we were rather marginal even then... So when you look at anything we are twenty, thirty, fifty years delayed, and this gap remains there... And only then [in 1990] we finally opened discussion of all the important themes

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<sup>38</sup> World Federation for Mental Health was founded in 1946 by the initiative of WHO by the director of Tavistock Clinic, John Rawlings Rees, with the original purpose of mental hospital reform. The scope of their mission was reformulated in 1947 “to promote among all peoples and nations the highest possible level of mental health in its broadest biological, medical, educational, and social aspects”. <http://www.wfmh.org/> Edith Morgan informally visited Czechoslovakia already in 1988, and encouraged her hosts – psychiatric professionals – to form an association to advocate for the rights of their patients.

that were addressed in the West in the 1960s that somehow fizzed through the whole society. The experience of the 1960s was simply exceptional – following the shock from the war in all the civilized Western world came this wave of revolt, of greater social sensibility, the desire to reform things and attend to the person in their individuality – all those hippies... With us it was a different story, something smuggled a little through in the Prague Spring, but all the energy was then consumed by the struggle with the monster... So we missed this impulse. Although in psychiatry there actually was some kind of new life awaking in the form of psychotherapy, few day centers were established, but nothing much was done in the area of human rights.”<sup>39</sup>

Dr. Ivan David expressed similar sentiment with respect to Germany:

“I would like it to be like in the beginnings of psychiatry where psychiatrists would go and train in Germany – because even 150 years ago Germany was thirty years ahead of us. And I think we should continue learning from them until today”<sup>40</sup>.

The ‘Return to Europe’ – a common motive of political rhetorics in the early 1990s – thus made its way in the psychiatry. One of the seminars on the reform of psychiatry from the mid-1990s bears the title *‘To Europe or Back to the History?’* – where the ‘history’ part is accompanied by the image of medieval torture rooms supposedly associated with the earlier psychiatric hospitals while the other part represents a map of Europe in bright colours. Psychiatry inevitable tends to be perceived as repressive – both on individual and institutional level – and the discourse of ‘liberation’ became an appealing concept in the context of radical dissociation with the totalitarian past. This past was perceived as trampling to human rights, autonomy and dignity of a person. The proposed transformation of psychiatry has aimed to introduce more humanity into the process of care, and create alternatives to institutions by introducing community care (this term itself is an idiom translated from English into Czech) which would ‘bring patients back to the society’.

The geographical distinction between East and West was understood in temporal terms as the chasm between past and future: overcoming the past was measured by the level of integration within Europe. This integration also meant accepting the values and practices: from the collectivist and egalitarian ideology of

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<sup>39</sup> Dr. Jan Pfeiffer, interview January 2008

<sup>40</sup> Dr. Ivan David, interview December 2007

communism to the self-conscious individualism and pragmatism of Western libertarianism. This also represent rather significant shift in social ethics whose impact was felt in medicine as well: from benevolent paternalism grounded in the notion of responsibility, to patients' autonomy and individual rights. The emphasis on patient's independence became one of the key objectives for transformation of psychiatric care. Dr. Pavel Baudiš, president of Czech Psychiatric Society throughout the 1990s commented on this:

“It seems that in elaborating and accepting ethical norms for psychiatric patients we are catching up with certain delay and it seems that even here – as well as in many other areas – we are significantly influenced by the standards and the thinking of the Western world.” (Baudiš 1996)

This reorientation became noticeable especially in the rise of the human rights discourse in psychiatry, as shall be discussed in the following chapter.

## Behind the Walls: Arts and Culture in the Process of Social Change



Festival Mezi Ploty, Bohnice hospital, 2008 (archive)

*“Of course it is true that in the history of humanity there has never existed a time when things were perfect and everybody was happy. Nevertheless, it has always been the role of a true artist to take note of things that are not as they ought to be. It is for these reasons that one of the most important tasks of art is to stir up trouble. The goal of the underground in the West is the outright destruction of the establishment.*

*In contrast, the goal of our underground is to create a second culture, a culture completely independent from all official communication media and the conventional hierarchy of value judgments put out by the establishment. It is to be a culture that does not have as its goal the destruction of the establishment, because by attempting this, it would – in effect – mean that we would fall into the trap of playing their game. The real aim is to overcome the hopeless feeling that it is of no use to try anything and show that it is possible to do a lot, but only for those who are willing to act and who ask little for themselves, but instead care a lot for others. Only by such means will it be possible to survive in dignity the rest of one’s life according to the prophetic words of the chiliastic Taborite Martin Húška: “The faithful person is a thousand times more valuable than any kind of ritual sacrament.”*

I. M. Jirous 1975

Since the world of mental illness remained largely invisible one of the essential conditions for any positive change was to bring psychiatry and especially the state of large psychiatric hospitals into public awareness. The project of ‘humanization of psychiatry’ was only thinkable if the indifference of the society and lack of interest of authorities were shaken to mobilize resources necessary for thorough reform. One of the major obstacles to this was also the stigma associated with psychiatric conditions – which indeed was very significant. When one physician asked in a survey in 1990 what would people do if they realized they are sharing a ride in an elevator with someone suffering from schizophrenia, the vast majority of the respondents said they would get off immediately.<sup>41</sup> The indifference towards people suffering from mental illness was considered to be a result of silence and ignorance: if people only knew what is going on in these institutions they would certainly be appalled by the conditions and would want to help. The assumption was that with more information about the nature of mental illness would make the public more welcoming to people who otherwise were treated with suspicion or even contempt and hostility.

One of the conditions for making the reform seen as necessary and possible was to make this hidden world visible and open to the view of the public. This was to be achieved in the first place by quite literally opening the gates and make the hospitals accessible for public – many of them are set within beautiful large parks and their use would then also benefit local communities – and allow them to encounter people who suffer from psychiatric illness. It was hoped that this contact might help to break down the suspicion and hostility associated with the ‘unknown’. The walls separating the two worlds had to be torn down.

Another way of facilitating the encounter of these two worlds was to publicize the life in the hospitals by the means of visual arts. There were several exhibitions of photographs documenting the life in the institutions organised at different venues in the early 1990s. But more importantly, there were many more

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<sup>41</sup> Dr. Filip Španiel, Prague Psychiatric Centre, lecture for students 2007



exhibitions presenting the art works of patients. The first such exhibition was open by Olga Havlová and supported by her *Committee of Good Will*.<sup>42</sup> The visual art was considered especially expressive means of communication between the author of the art work and the viewer. These exhibitions brought the hidden world behind the walls to the public spaces of exhibition halls and cafés.

Yet another strategy in this endeavour was the education of the public with the aim to change the attitude of the society towards psychiatric patients. The first initiative of this kind was *Weeks for Mental Health* organized for the first time in the autumn of 1990 in different places, offering lectures, workshops, concerts and various performances with the aim to raise public awareness of mental health and mental illness<sup>43</sup>. One key component of these *Weeks for Mental Health* was an art and music festival Babí léto [Indian Summer] organised by Unijazz – formerly an underground music band – which took place on the premises of the largest psychiatric hospital in Prague, Bohnice.<sup>44</sup> This was a way to do something enjoyable for people who were hospitalized there as well as to bring in the public and thereby create the space for an encounter of the ‘two worlds’. This festival became extremely popular with several thousands of people attending and has been organised annually for the past twenty years.

In 1991 another art festival, Mezi ploty – which literally means ‘between the fences’ – was established as its spring counterpart taking place in the hospital park with theatre performances, art workshops, and concerts.<sup>45</sup> One of the initiators of the festival, Robert Kozler, remarked on the origins and purpose of these festivals:

“In early 1990 I organised with friends an exhibition of paintings by physically disabled people in St Gilles monastery. Once on a way there I saw all the advertisements for Mozart, and somehow I connected these two motives and

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<sup>42</sup> Mosty No 6, 1991/1, p. 2-3; Mosty No 7, 1991/2, p. 3

<sup>43</sup> <http://www.tdz.cz/index.php?co=5>

<sup>44</sup> Unijazz is an organisation promoting jazz music, established in 1986 as a result of the banning of its ‘parental’ organisation, the ‘Jazz Section’ (established 1971) of the Czech Society for Music by the government. Jazz section was illegal since 1984, with several of its representatives condemned to prison for their cultural activities. <http://www.unijazz.cz/o-nas>. Since 2010 the festival is organised by the hospital. <http://www.babiletobohnice.cz/o-festivalu/>

<sup>45</sup> <http://meziploty.cz>

invented the festival. Our aim was to open the gates in the hospitals which used to have reputation of prisons rather than hospitals when we first started. We aimed to knock down the barriers between patients in the hospitals and the public. We managed to create a project that has an important social mission and yet is one of the most popular cultural events in the country. Our original idea was not to make any distinction between the artists with the handicap and those without, not to emphasize the disability in any way during the event or in its promotion. There is a lot of beautiful art filled with deep emotions being created behind the walls. This festival is a rather unique cultural event – unique even in the international context”<sup>46</sup>.

There is something to be said about these initiatives since they fit – and consciously situate themselves – within quite specific tradition of political resistance expressed through arts and independent culture in recent historical context.<sup>47</sup> During communism there was a law prohibiting public gatherings for reasons of potential subversion of the regime and any public event – cultural, educational, religious – had to be approved in advance by the authorities. Moreover, the content and form of the authorized events was often censored. The implication of this was twofold: the official public events were either occasions to promote the approved culture and ideology of the regime; and the events that indeed expressed a hint of subversiveness – often just by the fact that they represented an alternative or officially prohibited style or worldview – tended to recourse to symbolic or metaphorical language. They would seemingly comply with the official requirements but the hints of rebellion were clearly legible to their audience – people of similar orientation – as a form of ‘silent’ protest. One example of this is the *Spirituál Kvintet* which performed traditional religious songs of American slaves calling for liberation and freedom in a language free of any religious references and therefore not always decoded by the

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<sup>46</sup> Robert Kozler – compiled from interviews in Reflex, 21/2000, Lidové noviny 21.5.2008; and Idnes 16.5.2008. Festival Mezi ploty <http://www.meziploky.cz/cs/>

<sup>47</sup> The term kultura, ‘culture’ in Czech often refers more specifically to ‘arts’ – music, performing arts, visual arts, film.

censorship.<sup>48</sup> However, there were also other occasions of quite straightforward disobedience of the regime. In such cases no application for authorization of the event would be filled in and information of which would spread last-minute through the social networks of people who knew each other.

One of the iconic events were concerts by the underground group *Plastic People of the Universe* (established in 1968) whose members were imprisoned in 1976 after several years of systematic persecution.<sup>49</sup> They performed their own music alongside with music of bands they admired and were inspired by – *The Velvet Underground*, *The Mothers of Invention*, and *The Doors*, and their concerts were a sort of conceptual art events. The members of this band worked in close contact with other artist friends – painters, writers, poets, film makers, and together they organized concerts, film screenings and poetry evenings, as well as summer music festivals and various happenings. This unofficial art movement was referred to as ‘second culture’ – opposed to the official, ‘first culture’ supported and promoted by the regime – or simply ‘the underground’.

In the years of ‘normalization’ following the Prague Spring of 1968 *The Plastic People* as well as most other bands of similar orientation lost their official license and were banned from public performances. Although they continued recording their music most of their concerts were not approved by the authorities. In 1972 the first open conflict with the police occurred and the following year their artistic director Ivan Jirous – known as Magor [the Lunatic] – was imprisoned. These incidents escalated and in 1974 the police intervened in the secretly organized rock festival – *First Music Festival of the Second Culture* – where *The Plastic People* were among those scheduled for performance, and several musicians as well as

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<sup>48</sup> This ‘unofficial culture’ penetrated the world of the psychiatric research institution with otherwise strong commitment to neurobiological understanding of human nature. On the occasion of the anniversary celebration I attended in 2006 the afternoon series of lectures on neuroscience and psychopharmacology was followed by a concert by Spirituál Kvintet in the evening. This band was established in the 1960s and became popular through its songs – spirituals of the Afro-American Slaves which were full of symbolism of resistance and revolt and spread through the nation under the crust of the official arts. In 1989, tens of thousands of people joined them singing ‘Oh Freedom’ during demonstrations on Wenceslas square in Prague that became the Velvet Revolution. The audience of neuroscientists and psychiatrists joined in that night too.

<sup>49</sup> <http://www.plasticpeople.cz/historie/strucne-bio-o-ppu/>

members of the audience were arrested. (Another band affected was the ‘DG 307’ – its name is derived from the psychiatric classification in which diagnosis 307 stood for alcoholism – that in that time was subject to obligatory treatment. As noted earlier, the testing of limits of what was politically acceptable was essential part of their protest and a form of political statement).

The *Second Festival of Second Culture* planned for late February 1976 proved to be a final impulse for the official regime’s definitive response to these underground movements. Again, many of the musicians and artists participating on this event were arrested, some of them condemned to prison for several years after being tried for ‘rioting’ and ‘disturbing the peace’ – among them Ivan Jirous and the musician and protestant minister Svatopluk Karásek.<sup>50</sup>

Today *The Plastic People* in fact regularly perform at the open-air art festival *Mezi ploty* on the premises of the Bohnice psychiatric hospital in Prague, joined by other renowned bands of all genres, a variety of theatre companies and artists, writers and filmmakers to provide the two day lasting cultural programme with many performances and workshops in parallel sessions. Some of the performances are given by amateur groups including psychiatric patients and physically disabled people – a gesture that any social distinctions are irrelevant in this space, and many of the amateur artists commented on how privileged they felt performing with their most admired bands. There are also opportunities to buy artwork and manufactured products created as part of the art therapy – ceramics, paintings, woodwork and various kinds of jewelry – and even participate on some of the sessions organised together by therapists and patients.

The most important purpose of these arts festivals is to create a platform for people of different backgrounds and orientations to experience something *together*, representing a space where ordinary distinctions do not matter. It was hoped that this ‘togetherness’ would permeate society and make people more accepting and welcoming of difference. One of the journalists referred to the festivals on the

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<sup>50</sup> Svatopluk Karásek, following the imprisonment and a decade of forced emigration in Switzerland returned to Czechoslovakia and was elected a MP in the first democratic parliament. In 2004-2006 he served as a Government Commissioner for Human Rights.

premises of psychiatric hospitals as a '*practical training in social solidarity*' – people of different stages of life and of various social standing attend these festivals, and the artists do not accept any honorarium – all ticket sales is for the 'art fund' for the hospital, supporting art therapy and cultural events for the patients. Spreading to other psychiatric hospitals in the Czech republic these festivals attract tens of thousands of people annually. In this respect these new festivals can be understood in the tradition of independent culture which creates an alternative world, the 'second polis', closely intertwined with the strive for social change and expressing the respect of the individual, irrespective of their background.

These festivals also fit within a long tradition of arts present in the psychiatric hospitals in this part of the world. Most of the hospital complexes established in the late nineteenth century had theatres as one of the key buildings that – in addition to churches – provided spaces for people to meet and be together. In the early days of the hospitals there were amateur theatre companies – consisting of patients, nurses, physicians, and other staff as well members of the public – that provided entertainment and in some of the hospitals this tradition is alive until nowadays.

In the Prague hospital it is the 'The Bohnice Theatre Company' which in addition to the public performances and touring also participates on the drama therapy offered to patients. The theatre also hosts performances by various other companies, both professional and amateur – including one made up of medical students. It also organises concerts, annual balls, and lectures.

Recently, the unused and decaying building of the former hospital laundry has been transformed into another art space, *Prádelna Bohnice*. This alternative setting is beloved by contemporary artists both for exhibitions of the visual arts and modern experimental theatre. Additionally, it offers workshops for school children and young people to introduce them to art, creativity, and the experience of mental illness.<sup>51</sup>

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<sup>51</sup> <http://www.pradelnabohnice.cz/>

The idea that arts and culture represent a unique meeting space for the ‘two worlds’ also inspired another initiative aiming to facilitate return of patients from the hospital into the community. Dr. Martin Jarolimek, one of those psychiatrists who established such first community services, came with the idea of establishing cafés as cultural spaces that would provide common ground for meeting of patients and the ‘outside world’:

“With Pfeiffer and Pěč we founded the first NGO, Fokus, with classical sheltered workshops. One of them I placed here, on the same floor as my office. I acted as a director for several years but then at a certain point I had enough of that because I became conscious that these classical workshops were somehow surpassed – I often visited England and there I saw it: it creates a small ghetto, where ten chronic schizophrenic patients and therapists perform monotonous simple work for many years. And because the clientele was changing – these days we get more and more young people – this was one of my concerns. The psychosis first develops between the age of 13 and 19 and the sooner you get hold of psychosis the more influence you have over the positive outcome of treatment. I thought that these young people, these kids with psychotic illness need something else than classical sheltered workshops, and therefore I founded a NGO ‘Green Doors’. These are cafés where they can work as a way of social rehabilitation, the most well known the one here nearby, *Na půl cesty* (‘Half Way’), and the one in Jelení. This idea actually came into being walking from the subway to here, that is why it is called Half Way... Then I also managed the tour de force – to establish one in the very center of psychiatric hospital in Bohnice, in the theatre building, and I called it the ‘Fifth Column’ – which is a reference to the military term from the World War I where there is a smaller unit within a greater unit and its goal is to be destructive for the army from within. We had a little argument with Zdeněk Bašný, then a director of the psychiatric hospital, who got the rather provocative thought. We organize concerts there every week, and also exhibitions and other cultural events.”<sup>52</sup>

These cafés grew in numbers in Prague and elsewhere and soon became very popular meeting places. This idea was implemented also in some psychiatric hospitals where patients work not only in the cafés but also run groceries and newspaper shops. Patients also staff small galleries around the town where various products from handicraft workshops and art therapy are sold.

This model also inspired other initiatives of reintegration of people with different forms of disabilities. Martin Jarolimek continues his account:

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<sup>52</sup> Dr. Martin Jarolimek, interview January 2010

“It proved to be a very good model because these cafés offer a wide spectrum of activities – from cleaning the floor, bathroom, making coffee and drafting the beer... I myself worked there for half a year to find out what it is all about – to what I am about to expose my patients. I elaborated a special rehabilitation system – each client has their patron and follows individual rehabilitation plan. We now employ more than 250 people in this occupational therapy in the café. People from different towns came to see it and they all liked that –the cafés became quite popular. They asked us about the know-how of how to run such a place and we gladly shared with them. I was going to different places and was helping them to establish these cafes. There is now about ten such places, and some of them are even called Half Way. Once my Danish friends came for a visit and brought their friends from Dublin and they also invited me there since they were so excited about the idea. So I have one Half Way in Dublin, too. We even had a first symposium, or rather mini-conference in Budapest of socio-therapeutic training and sheltered cafés, since gradually more and more people became interested and implemented this model. Now there are different variations for people with different disabilities – blind, mentally handicapped – such as *The Firefly* and *The Universe*.”

These cafés host large variety of events – from concerts, lectures, exhibitions, to literary readings and travel documentaries – and bring together people that would otherwise not be likely to meet. They became quite ordinary part of the cultural landscape – in one of the news reports they have been called as ‘Cafés with a meaning’.

All these various initiatives in the area of arts and culture thus share the same aim – to communicate through art that we all share the same human condition which can be a source of both suffering and creativity that allows for transformation of experience into something worth and powerful in communication with others.



Café Fifth Column, Bohnice hospital, 2007





The former laundry building before being converted to theatre Prádelna, Bohnice 2007



‘Twofold world’ store with products from various patient’s workshops, Prague 2007

## Chapter 2

### The Proposal for the Transformation of Psychiatry

#### Institutions and Communities in the Care of the Mentally Ill

*“It has been said many times already that large psychiatric hospitals are inhuman institutions in which patients are neglected and abused, where the rigid hierarchy leads to arrogant, rejecting and even abrasive treatment of patients. Some call for the humanization and modernization of psychiatric hospitals, some for their complete abolition and therefore de-institutionalization of psychiatric care.”*

Dr. L. H. 1991<sup>53</sup>

Institutional care in the socialist Czechoslovakia served a wide range of the population: children's homes (orphanages) and homes for physically and mentally handicapped children, institutions for adults with various forms of disabilities, and homes for the elderly with long-standing conditions who were no longer able to look after themselves. These were mostly large institutions with several hundreds of inhabitants each. In addition to several purpose-built facilities many of them were located mostly in former monasteries, mansions and castles – expropriated and nationalized in the early 1950s. Unlike most of these institutions that are currently within the remit of Ministry of Labour and Social Affairs, the psychiatric hospitals and long term hospitals for the elderly remain within the responsibility of Ministry of Health. The social care institutions have been undergoing a systematic reform process aimed to improve the standards of care since the 1990s – often on the initiative and significant assistance of numerous charities and non-governmental organisations who in collaboration with regional governments supplement the state provided care. The objectives of the transformation of institutional care were provision of care in smaller facilities that allow for more personal approach to the clients, improving the living conditions in the institutions, strengthening social services network for assisted living outside the institutions, and training of the staff.

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<sup>53</sup> Dr. Leoš Horáček, Mosty No 5, 1991/2, p. 12



However, despite the partial progress in de-institutionalisation it is estimated that more than one hundred thousand people – around one percent of the population – live in institutional care as of 2012.<sup>54</sup>

Similar objectives were proposed for the transformation of psychiatric care as initiated by the Czech Society for Mental Health in collaboration with psychiatrists. The aim was to establish alternatives to institutional care which was perceived as poor and overcrowded, insensitive to the needs of the patients, and outdated. It is generally agreed that many – maybe a third – of the patients who are hospitalized for the long-term in institutions are there for ‘social reasons’, i.e., not having anywhere to go – they do not have a family willing or able to take care of them. Many of them would actually be able to live a more independent life with some degree of assistance. Their medical condition is usually stable – there is not much that medicine can do for them – but because they have nowhere else to go they represent what psychiatrists refer to as ‘undischageable patients’. Although the reform in the area of social care has been more progressive than in the area of psychiatry, the attempt to increase the standard of living in social care institutions led to their downsizing with many less places available as a consequence. However, because these patients do have a psychiatric diagnosis it is the hospitals that have a duty of care towards them. Dr. Ivan David, the director of psychiatric hospital Bohnice, explains the implications of current situation:

“We admit and take care of patients with all possible conditions for whom the outpatient care fails, and we also take care of patients who would not and even should not be here but who are here because nobody wants them. This is not our fault nor our merit. This is our legal obligation: we cannot discharge anyone when there is no one to provide care for them. And to discharge someone only to have him come back as a homeless person in a month time is irresponsible – but there are times in which we unfortunately have to recourse to that because we do not have sufficient capacity to accommodate all patients in need. However, we still do admit all patients who need it urgently, all of them, and we would be able to do it much better if we had more finances to pay for more staff. Then we would also be able to provide a better standard of living which would improve the quality of life of the patients. If you have ten patients in one room and according to different treaties everyone should have a right to privacy, this is simply not possible. Again, this is not our fault nor our

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<sup>54</sup> [http://www.podporatransformace.cz/?page\\_id=72](http://www.podporatransformace.cz/?page_id=72)

merit but this is what we inherited. These hospitals were build a century ago for 1200 patients, at certain periods there were 2500 patients living here and now it is 1400, but one hundred years ago the standard of living were entirely different – people were poor and accustomed to lay their head in the hay... For that time these premises were magnificent and extremely generous. And so although we admit and provide care for anyone in need we are unfortunately unable to provide the twenty-first century standard of living because they save money on these institutions very successfully – we get 40 euros per person per day, poor Germany gets 340, France 460, and Norway 680. My international colleagues kindly laugh at me when I tell them.”<sup>55</sup>

Hospitals thus take care of patients with longstanding but stable psychiatric conditions who – in the absence of the family – should be eligible for social care. However, the indication of a ‘psychiatric condition’ in patient’s documentation serves as an exception of eligibility for social care institutions. The rationale for this is that they require more care and might be difficult and disturbing to other residents in social care institutions. Although there are a few social care institutions specifically for psychiatric patients (most often elderly patients) the waiting lists for those are very long – currently between seven and ten years – and as a result many of the patients wait in vain, some of them die before they can be transferred or their condition worsens so that they are not eligible anymore. These social-psychiatric institutions, too, are in remote areas which often contributes to the difficulty of contact with their families and friends – if they have any. Dr. David continues his account:

“Nobody cares about the hundreds of patients who wait in vain for the social care institutions. Although there is a legal duty of the state and local authorities to provide this care, this duty is irrecoverable – it is actually rather ironic legal provision: the local authorities have a duty to provide social care to a person in circumstances in which the lack of provision of care would endanger their life and health. However, if their life or health is endangered, it is the hospitals who have a duty of care. In other words, the local authorities in fact are relieved of their obligation and therefore do not care about anyone.”

The care for chronically ill patients thus represents an intersection of healthcare and social care and the unclear division of responsibility accounts for the lack of comprehensive approach in this area. This also impacts the continuity and quality of

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<sup>55</sup> Dr. Ivan David, interview December 2007

care. There is very little collaboration between the Ministry of Health and Ministry of Labour and Social Affairs within whose remit the long term care belongs. There has been no constructive debate on the highest political level of ministries responsible for health and social care. Currently, social care has been partially delegated to regional authorities with both state and non-state providers, the hospitals hosting small acute psychiatric wards have been privatized, while majority of the psychiatric institutions are directly under the Ministry of Health. The fragmentation of the system disperses the responsibility for comprehensive care of people with severe psychiatric conditions.



Pavilion for male patients, Kosmonosy hospital 2007

During my time in the Kosmonosy hospital I witnessed plenty of phone calls every day from patients, their families as well as outpatient psychiatrists demanding admission to the hospital – as well as attempts of the hospital staff to transfer some

of the patients to social care institutions to make space for new ones – attempts which most often were in vain. However unpleasant the conditions of the hospitals are, they are the last resort and their capacity is still finite. This often leads to frustration among the doctors. The head of the admission ward in Kosmonosy told me, after responding a third call requesting admission of patient within the last hour: *“We are overwhelmed by patients to whom we can not really help, and for those whom we might be able to help there is no space.”* For many of these patients, though, there is really no other place to go. Even in cases where some form of home care assistance would be sufficient for many of them there is no home to go.

Dr. David Holub, then a director of a psychiatric department of Ostrov hospital comments on the situation in his region:

“Our work provides us with the immediate closeness with the patients to see their needs and adjust the services we provide. We offer a demanding psychotherapeutic program, as well as art therapy and cognitive therapy training. Our utmost priority is to allow people with severe psychotic illness to return into life. However, we experience a sense of hopelessness when we discharge well stabilized patients in awareness that there is no adequate care and support provided for them in the community, and that sooner or later they will be back. The care outside of the hospital is in a catastrophic state, one of the most lagged behind areas in our society. Politicians and administrators responsible for social care and health care have no interest in this whatsoever. In the proposed conception of psychiatric care the recommended ratio is 136 acute and 165 long-term beds for 300,000 citizens. We currently have 23 and 25 instead.”<sup>56</sup>

One of the key aims of the transformation of psychiatry was therefore to provide more outpatient care and support in the community for patients who would manage independent life outside the hospitals with some degree of assistance. The purpose of establishing community care was to increase the overall capacity and accessibility of the psychiatric care, allowing for greater differentiation of services and improving the continuity of care between different providers. Community care was seen partially as an alternative and partially as a complement to the psychiatric hospitals and outpatient psychiatric care.

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<sup>56</sup> Dr. David Holub, interview for Mladá Fronta Dnes, 3.12.2004

One of the aims of the Society for Mental Health in 1990 was to create an organisation – or rather a network of organisations – that would provide community care. It was especially the younger generation of physicians and some of the older generation who were in contact with the Charter 77 movement that took the initiative forward with great enthusiasm. Their hope was to make the society more welcoming to people who are currently dependent on institutional care. Dr. Jan Pfeiffer who at that time worked in Prague Psychiatric Centre recalls:

“Our vision was surely grandiose. We thought that we would create alternative system in which the traditional one would completely dissolve. In addition to our clinical work in the hospital we organized patient groups, and then went somewhere in the remote highlands to establish new community services. It was a time of great naiveté, and enthusiasm. We established one facility almost every week.”<sup>57</sup>

There were many features of the movement which were quite unique to this post-revolutionary period. One of them was the abandonment of professional roles and hierarchies that separated the patients and their carers thus creating a ‘communitas’, therapeutic community where social distinctions are considered irrelevant and people just are together. Dr Pfeiffer recalls his initiative that resulted in one of the first NGO’s of this kind:

“We would spend a week together at someone’s cottage. It was mainly the three of us who left the research institute for this new organisation – a psychologist, a psychiatrist, and me. And one more person, actually – she was a cleaner, she was a natural talent and one of the greatest therapists, she would just talk with patients, while working in the garden with them. She was just amazing and helped the patients to go through this separation process although she had no education at all. And since there were no special schools for this kind of work we employed more and more uneducated people, and it resulted in some kind of tension – the trend was that to be a professional one has to be non-professional. It was a world on its own that had nothing to do with the world of official psychiatry.”<sup>58</sup>

The ‘communitas’ where the distinction between professionals, lay persons and patients faded out was very typical of similar unofficial or underground initiatives of the pre-1989 times. In the ‘official world’ of communist society the

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<sup>57</sup> Dr. Jan Pfeiffer, interview January 2008

<sup>58</sup> Dr. Jan Pfeiffer, interview January 2008



presumably egalitarian ideology was actually characterized by hierarchies of comrades, with various distinctions and discriminations. As a form of resistance to these imposed patterns of behaviour, the 'unofficial world' often tended to the contrary, creating a communities of people sharing the same beliefs or interests. This was the case of the dissent movement as well as various artistic and religious initiatives (Bolton 2012). Possibly, these new communities, as well as gatherings of people around psychotherapy, may be considered as a continuation of these patterns in new circumstances.

This was a sentiment that reflected the overall atmosphere and hopes of the early post-1989 era: the dissolution of the past system in the new civil society. For psychiatry this meant discarding the old institution that represented the repressive totalitarian regime with a more attentive and personal care in the community. Dr. Martin Jarolímek recalls of that: *"It was a very enthusiastic time when we thought that here in the Czech Republic the same process will happen as in England, the process of so called de-institutionalization."*<sup>59</sup>

These psychiatrists and other professionals established several organisations in different regions (although most of them were concentrated in Prague) to provide a range of services in the community in areas such as psychotherapy, psychosocial rehabilitation, sheltered workshops, gardens and farms as part of occupational therapy. There were also several sheltered home initiatives established as an alternative to the life in the hospital. Some of them were simply community centers with meetings for mutual support, some provided legal advice to patients. Additional obstacle for the integration of patients within communities was that there were very few employers that were willing to employ someone with special needs, be tolerant enough to the potential symptoms of their illness and adjust their working environment, such as lowering of stress levels. As a result many patients who are interested in even part-time work are not able to find any employment and easily became dependent on disability pension support – which nevertheless is rather minimal. It was perceived that the whole society needs to change in order to be

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<sup>59</sup> Dr. Martin Jarolímek, interview January 2010

willing accommodate to the unique needs of people with mental illness. Those who were negotiating to overcome these obstacles were of the opinion that those people often could contribute to the society in creative, insightful, and productive ways and, in addition, gain satisfaction from meaningful work.

Many of my informants recalled how favourable the early 1990s were for these kinds of initiatives since there was a sense of revival in society and enthusiasm for replacing the old totalitarian regime by new civil society. Existing institutions were perceived as a materialization of the oppressive past, while the community care appealed as a model for society that is truly inclusive and respectful to the individual. They often mentioned the ease with which it was suddenly possible to establish any initiative with a legitimate social agenda as an independent organisation, and also the relative accessibility of finances from foreign governments and private institutions for whom the fall of communism in Central and Eastern Europe represented a worthwhile cause. However, until this proved to be also the weak point – these various community services are still run as NGOs, dependent on grants from the state, regional governments and structural EU funds to continue their work. They did not become part of state financed network of social care. Although they are generally acknowledged to be a more vital and personal form of care for people with chronic form of mental illness than the institutional care, they remain solely the initiatives of individuals and charities and the state does not take any responsibility to support their work and therefore does not guarantee the availability of the services to their clients.

Some of the psychiatrists establishing community services left their previous employments to devote their time and effort fully to their new mission to replace the old system of institutional care with a the new one, based on care provided in the community – and these were the most radical. There were however others who used their positions in the hospitals to reform the system from the inside, and to develop additional forms care to complement that of the hospitals. Dr. Zdeněk Bašný was one of those. He acted as director of the Bohnice hospital in 1990-2005 and recalls that

his all life he has been surrounded by the world of psychiatry – he was actually born in one of the hospitals while his father was a psychiatrist and lived in the hospital with his family. That was not uncommon in that time – all the hospital complexes included villas intended to accommodate the doctors and nurses. While studying medicine, he worked as a psychiatric nurse and later became psychiatrist himself. He was familiar with the history of psychiatric care in Czechoslovakia but also had a keen interest in the international experience with psychiatric care, to which he devoted his public health thesis. After his appointment as a director of the Prague Bohnice hospital in 1990 he attempted a thorough transformation of the hospital:

“My aim was that this hospital would become a torch in the process of transformation in our region so that it will not be a traumatic experience for anyone to ‘go to Bohnice’.<sup>60</sup> We aimed to revitalize the hospital environment, decrease its capacity in order to improve the quality of care, and allow for greater differentiation of services according to the needs of individual patients. I divided the wards into three categories: treatment wards for acute conditions, care wards for chronic conditions, and so called ‘social beds’ for people who had nowhere to go. We also wanted to use the amazing potential of the hospital area for rehabilitation activities – we reopened the farm and used it for social rehabilitation programs and I opened the space for the arts festival and other initiatives. We wanted to take people out from the hospital and provide for their care elsewhere and therefore we established a foundation that negotiated with the municipality to have returned the many additional houses in the area that originally belonged to the hospital and transform them into sheltered housing for patients. We experienced that many of the patients keep returning after being discharged and we actually did not know why – their psychopathological condition was not too serious but they just could not manage life in the outside world. We wanted to create conditions for psychosocial rehabilitation in a sheltered environment to enable them to gradually regain their skills and help them on their way back to society.”<sup>61</sup>

He partially achieved this through his Bona foundation that provides sheltered homes and other services in the north part of Prague.<sup>62</sup> These are several houses in the vicinity of the hospital and each accommodates around thirteen patients – actually here they are referred to as clients rather than patients to signify the

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<sup>60</sup> This is an idiom used in common language that refers to being mad and stepping into ‘another world’.

<sup>61</sup> Dr. Zdeněk Bašný, interview December 2007

<sup>62</sup> ‘Bohnická nadace naděje’ – ‘Bohnice foundation for Hope’ = <http://www.nadacebona.cz/>, <http://www.bona-ops.cz>

change in their status that the moving out of the hospital represents, as well as the voluntary nature of the contract. They live together, cook together, take care of their home and the laundry, organise their time and manage their finances, and through this they learn to live more independent lives. These houses look like homes rather than hospital rooms with their distinctive decoration and spatial arrangement that provides both for privacy and socializing.



Common room, Bona sheltered housing, 2007

Each of the houses also have a therapist in residence who assists the clients with their contact with the outside world and planning for their independent future. The therapists also make sure they regularly see their outpatient specialist psychiatrist and take their medication. Dr. Bašný comments on this:

“The whole program was based on the idea of taking people out from the hospitals and allowing them life in the community, but soon we realized that those with lesser handicaps go home directly and here we are getting those who indeed would otherwise be dependent on the care of the institutions. The institution has always

been an alternative for those with more serious handicaps, with the more severe form of illness, but it is extremely hard to achieve any rehabilitation in the hospital environment. But nevertheless, their condition seems to be much more stable if they live here, they manage with regular visits to their outpatient psychiatrists, and here they have the support they need.”<sup>63</sup>

These sheltered homes are therefore more a substitute for a family environment which in many cases is unavailable to these clients, and when I visited some of these houses the clients indeed referred to this as their home, as their family. Sometimes their original family is absent, sometimes the connection is lost – often as a result of the illness. Even in cases where the patients do have a family that provides for them, the time comes when their parents who often are their primary carers get older and frail, and eventually pass away. This is the point when even those who have lived with their families often become dependent on the institutions.

Although originally intended for stays of up to two years, the rules for the sheltered housing had to be renegotiated because the clients have nowhere to go after this period of psychosocial rehabilitation. The sheltered housing therefore faces the same dilemma as the psychiatric hospital – how to accommodate new potential clients who need such an arrangement when there is nowhere to transfer the current residents in order to make space for them? The ‘community’ in the term ‘community care’ refers more to the community in these sheltered environments rather than to the community of the society which generally is quite reluctant and uninterested in integration and welcoming them as neighbours.

Another service that Bona foundation provides is home care for patients who are able to live independently – and have their own homes – but occasionally need an assistance with various issues. They employ several psychologists and social workers to look after their clients. These services are complemented by several handicraft workshops and gardens in which the clients might wish to work, as well as a library, arts and education centre, and a small store called ‘Twofold World’ in the center of Prague where the products of the workshops are sold, staffed by the clients.

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<sup>63</sup> Dr. Zdeněk Bašný, interview December 2007

Since these new forms of community care are classified as a form of social – rather than medical – care there is rather unclear division of responsibilities between these two realms. The patients with chronic conditions receive a disability pension and disability support from the Ministry of Labour and Social Affairs. The recent Social Care Act (2006) also changed the financing of social services in the sense that the clients – rather than the service providers – get the funding which they use to ‘purchase’ various services. This arrangement was supposed to strengthen the clients’ autonomy as well as introduce market incentives into social care. In Bona homes, the clients sign the therapeutic contract that stipulates the rules of this arrangement and specify the services they require and decided to purchase. The responsibility thus rests with them. With a sign of laughter Dr. Bašný adds: *“They have to order the services they need, but many of them prefer to get themselves a box of cigarettes than to order the specific services they need for the 85 Kč they get for this. Then we have to find other ways to deal with that and provide them with what they need.”*

In contrast, the financing of medical care in psychiatry is through the health insurance companies which reimburse the care on a ‘point’ based system and partially finance the medication and other forms of therapy, with the Ministry of Health additionally contributing to the financing of psychiatric sanatoria. The fact that limited resources have to be shared and the provision of more expensive treatment in one area necessarily limits the provision of care in other areas contributed to the gradually growing tensions between those who aimed at psychiatry reform from the inside – improving conditions in hospitals and providing additional services to complement the hospital care – and those who aimed to create completely new system based on ‘communities’ to replace the institutional care. In the beginning the disagreement was mostly about what are the most appropriate forms of treatment and what environment is better suited to meet the needs of the patients. There was a tendency to emphasize either the medical nature of psychiatric illness, or the psychosocial context within which the illness occurs. However, both groups were of

the opinion that psychiatrists represent the profession best suited to take care of people with mental illness and they were rather reluctant to negotiate better arrangements in the area of social care which they saw as insufficient to address the medical needs of the patients. Nevertheless, the blurred line between the ‘medical’ and the ‘social’ gradually led to disagreements within the psychiatric profession on what is actually the purpose and scope of psychiatry and how far the psychiatrist should go in attempting to improve life conditions for their patients. As time went by, the whole debate became a battlefield over the flow of finances and the vision of various forms of care within psychiatry, and the representatives of these two groups were increasingly less willing to collaborate with each other. The hospital psychiatrists became suspicious of those receiving various grants to support the work of their NGOs that they do it for financial gain. Those psychiatrists working in NGOs have been criticizing those in the hospital that they want to retain their professional power over the system and are consuming the finances which should go for development of community care rather than to support the unreformed institutions. These tensions resulted in significant personal hostilities – even in my interviews fifteen years later I witnessed bitter questioning of their opponents’ interests and intentions.

Even among the community care proponents the tensions were growing since they often did not agree on the conceptual visions or the particular ways to move forward with their initiatives. This is demonstrated by the fate of the initially promising Society for Mental Health that grew from the patients’ club to an umbrella organisation for initiatives in the area of psychiatric reform. The perspectives of two of its founding members illustrates the nature of the disagreement and the different perspectives they came to adopt:

“Unfortunately, this spontaneous tripartite arrangement of patients, therapists and lay public, whose principles were promoted through the Czech Society for Mental Health was already in the early 1990s progressively destroyed by the rising ambition of sociotherapeutic professionals to subject everything again to their ‘need to help’ which actually was just masking their ‘will to power’. As a result, our new model of community consequently eroded and disappeared – the therapeutic dynamic was again usurped only by the professionals. The patients subsequently started to emancipate from this non-dialogical embrace by establishing their own –

unfortunately closed – patient organizations, and the ‘interested public’ lost interest in these degraded relationships, or rather, in this bi-polar arrangement there was no space left for their integrating and dialogic influence.”

“To conclude the story about the Czech Society for Mental Health, one of those in the leadership of the society was rather schizoid person, attached to the patients, making them dependent, and by her influence the society gained an anti-psychiatric edge... Since Bolshevik was here the Czech psychiatry did not go through the anti-psychiatric wave as elsewhere in the world, and it came around in this form much later... They excommunicated me and Kamil Kalina from the Society, and the whole leadership was formed by patients... Because we still wanted to retain contact with the World Federation of Mental Health and we could not have the same name as the anti-psychiatry one, we established the Association for Mental Health – as opposed to the original Society for Mental Health. We still organize many activities through this association.”

The were disagreements on the aims of the transformation as well as on the means to achieve the goals. Various organisation originally unified in their aims later diverged in their objectives which ultimately weakened the case of this reform movement. Dr. Jan Stuchlík, one of the community care proponents, remarks:

“The Prague Fokus was established in 1990 and in 1992 we established our own in Mladá Boleslav as an independent organisation. The aim was to create a system of rehabilitation and a system of care for patients who require long-term care in order to prevent recurrent hospitalizations. And elsewhere we started with what we knew well – the sheltered workshops: it is easy to explain to anyone that we need to provide people with job opportunities. Very soon we realized that this was not enough, though. It is perfect arrangement for a small number of people of this target group. People who are able to attend daily and are motivated. The data show that these people require 3.5x less hospitalization than average. However, this is only a tiny proportion of people with psychosis who can manage like that, maybe 20 or 25%. The rest of them cannot manage this at all, they are not physically capable of that or are not motivated enough, they might be not anchored enough in their lives, and for many other reasons. And so in 1995 with the assistance of our Dutch colleagues we established this institution, the Center for Mental Health Care Development, which derived from the Prague Fokus. It was lead by Dr. Jan Pfeiffer, who established the Focus, but was continually getting into conflicts with his colleagues, since his vision was a change of the system, and not the development of services of one specific organization, and these interests got into conflicts. He then established this center and secured funding for that. It is an organization interested in methodical work, research projects, education, conceptual and policy work, and it also provides the



resources for the Conception for the Transformation of Psychiatry’ – which never succeeded, though.<sup>64</sup>

There is something like a general pattern to this constellation that holds not only for this specific case of psychiatry but to the post-socialist society in general. In his essay on dissent and democracy, the French philosopher André Glucksmann observes that unlike social movements shared by common roots in history, religion, or culture, dissent retained the plurality of religious and cultural identities and political orientations. It was therefore not an ideology that held them together but rather the threat under which they lived, the shared awareness of menace (Glucksmann 2010; Pithart 2009). This is something that Václav Havel acknowledged already in his 1978 essay, *The Power of the Powerless* when he asks: “Perhaps all this is only the consequence of a common threat. Perhaps the moment the threat ends or eases, the mood it helped create will begin to dissipate as well. The aim of those who threaten us, however, is precisely the opposite. Again and again, one is shocked by the energy they devote to contaminating, in various despicable ways, all the human relationships inside the threatened community.” (Havel 1978)

Having a common enemy obscured the differences of people that came from many diverse backgrounds and which indeed contributed to the success of the dissent movement. With the fall of the regime, after relatively short initial period of enthusiasm and seemingly unified in their vision, the new conditions revealed the variety of conflicting ideas and ideals among them.

In the political realm the Civil Forum which organised around the Charter 77 and led the society through the events of 1989 disintegrated shortly thereafter into factions of differing political orientation. The initial anarchic phase slowly transformed into a more traditional political system with the antagonisms of the different parties, characterized by disagreement regarding what constitutes the public good and what the political – and especially economic – priorities are (Eyal 2000).

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<sup>64</sup> Dr. Jan Stuchlik, interview December 2007

Something similar happened in psychiatry as well: the shared discontent with the inherited situation and the conviction that the system which tramples the dignity of the vulnerable individuals has to be abandoned and replaced did not necessarily translate into a shared opinion on what alternative arrangement should be pursued. Everyone agreed that the current conditions in large psychiatric hospitals are unsuitable for many patients who with different degrees of assistance would be able to live more independent lives. However, they had very different opinions about the alternatives and their perspectives and interests were becoming more divergent and conflicting. The state seemed to be the utmost enemy, but with the inaction on its part, these various actors originally unified in their mission unfortunately turned enemies with each other. The scene polarized between advocates for the improvement of care in current institutions and those advocating the abolishment of the institutions for care in the community. The conflict had a strong symbolic charge around the question of how to deal with the inherited past – should the burden of the past be left behind and forgotten or gradually re-formed into something more appropriate for the new circumstances?

## Negotiating the Responsibility between the Profession and the State

By the mid-1990s the debate on the transformation of psychiatry moved from the unofficial forum where it was initiated by psychiatrists, patients and their friends to the arena of the professional organisation, the Czech Psychiatric Society. The medical profession in the Czech Republic is organized into societies representing different medical specialties which are also a negotiating partner to the Czech Medical Chamber and the Ministry of Health. In early 1990' the representatives of community care initiated a proposal for a complex transformation of psychiatric care and presented it to the Czech Psychiatric Society. This was not entirely straightforward: the initiators had to negotiate with both the Czech Psychiatric Society to officially sponsor this project, and with the Ministry of Health to commission it. The aim was to review the current state of mental health care and in accordance with modern trends propose a plan for its reform. The Ministry of Health did not have much interest in this area since it was preoccupied with more urgent issues – the economic transformation of healthcare. Only after several years of negotiations the Ministry of Health finally agreed to commission the project, although the initiators had to provide their own funding for the project – which they secured from the Open Society Fund Dr. Jarolímek recounts on this initiative:

“Our enthusiasm lasted for maybe five or six years, and within that time, we formed a small group – Pfeiffer, Stuchlík, Pěč, Jarolímek, and we drafted a conception of psychiatry and persuaded Czech Psychiatric Society to name us officially as a working group for the drafting of that document. In parallel we also worked on the mental health law – which never made any progress, only now we are working on the law again. It was a very long process to persuade the psychiatric society to accept this document. Professor Raboch – who was recently elected as a president of the Czech Psychiatric Association for the sixteenth time in a row – and who is a rather conservative, accepted that at the end, and now he declares it as his document, our names do not appear there anymore...”<sup>65</sup>

The resulting document is entitled *The Conception of the Transformation of Psychiatry* and has a rather peculiar history. Tracing the trajectory of this document from its inception through the different phases of negotiation provides interesting

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<sup>65</sup> Dr. Martin Jarolímek, interview January 2010

insights in the relationship between the profession and the state and into the character of civil society in the post-socialist context.

What is important to remark at this stage is the fact that the whole project of psychiatric reform was entirely the initiative of psychiatrists themselves, in the beginnings with contribution of several lay people. However, there was never any interest, initiative or contribution of the state represented by the Ministry of Health. This is something that is unusual in other countries where reform was attempted since the 1960s as these often had an anti-psychiatry motive present in the beginnings of the initiative, and where it was the state that in some way initiated or facilitated the reform of mental health care towards community care and de-institutionalization. Retrospectively, the intellectual roots of the anti-psychiatry movement are often considered a concealment of the primarily economic reasons for this change. Also, law and policy makers, and other professionals such as nurses and social workers played much more important part in the transformation of psychiatric care and there was at least some kind of public debate in other contexts – whereas the involvement of these other parties and wider public was practically non-existent in the Czech Republic.

In 1992 the *Committee for the Conception of Psychiatric Care in the Czech Republic* was established by a group of psychiatrists gathered around the Association for Mental Health Care to work on a proposal for the complex reform of the system of care for people with psychiatric conditions. Their aim was to take into consideration the various needs of their patients and propose ways in which these needs might be addressed in a more differentiated system of care. This initiative soon became formally associated with the Czech Psychiatric Society. Representatives of different sections of this organisation were delegated its members to the committee – outpatient specialists, psychiatrists working both in the psychiatric wards of general hospitals and those working in psychiatric sanatoria, advocates of the community care, specialists for geriatric and pediatric psychiatry, and various representatives of academic psychiatry. Two years later, in 1994, this document was finalised and submitted for approval to the Czech Psychiatric Society. However, the Society

decided not to authorize this version as the official statement and recommendation to the Ministry of Health because in their view it addressed mental health care policy rather than psychiatry in the strict sense. The document justified the necessary transformation to address the life circumstances of mentally ill people and their status in the society, including attention to their psychological and social needs, as well as the social stigma. This approach was perceived by the Psychiatric Society to go beyond the scope of psychiatry as a medical discipline. Therefore, in 1995 the Czech Psychiatric Society decided that it was necessary first to outline the conception of the psychiatry as a purely medical specialty. Another committee was established for this purpose, chaired by Dr. Jan Pfeiffer and again including representatives of various groups within the psychiatric community and additionally several international experts. The final version was then approved by the Psychiatric Society in 2000 and accepted by the Ministry of Health two years later.

Dr. Pfeiffer comments on the initiative:

“It took us several years: we collaborated with different experts and various organisations, and it really was a fair amount of work. The Psychiatric Society approved it, then the Psychiatric Congress approved it, and finally the Ministry of Health approved it in 2002 – the scientific committee of the Ministry of Health. But that is it! No implementation! It is just a piece of paper!”<sup>66</sup>

In 2004 – two years after the formal acceptance of the proposal – the Ministry of Health established the Implementation Committee for this proposal. Dr. Jarolímek, who was involved provides further details of this process that extended over number of years:

“Well, after that we visited four – at least four – ministers of health care, the maximum we were able to achieve was that the so-called scientific committee of the minister Součková accepted this document, but it has no real significance... She then named the implementation committee which included the president of the Psychiatric Society Raboch and others like him so nothing happened at all... Some time later the minister Julínek recalled this implementation committee because it was not doing anything at all. As a response, Psychiatric Society immediately named a new working group for the revision of the conception of psychiatry and they came with a revision which was recently introduced in the congress in Špindlerův Mlýn.”<sup>67</sup>

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<sup>66</sup> Dr. Jan Pfeiffer, interview 2008

<sup>67</sup> Dr. Martin Jarolímek, interview January 2010

This time, Dr. Zdeněk Bašný – who had experience both as a director of the largest psychiatric hospital and founder of several community based projects – was appointed to chair this committee. The process was similar as before: experts in various specialties and institutions were asked to prepare their own version of the proposal and these were then posted on the website of Czech Psychiatric Society so that anyone could read and comment on that. However, at this point Dr. Bašný was rather skeptical about the whole process of debate that gradually lost its momentum and diminished in intensity – the individual psychiatrists either got tired of it or grew more resistant to any change. He analyses the situation in a following way:

“The psychiatric community is fragmented – and it has always been. Those who take any initiative mostly present extreme opinions, once it was Jan Pfeiffer, then Ivan David, and now they are buried in their trenches. The community activists found their enemies in the hospitals, and as a response, the wave of aversion arose from hospital psychiatrists, an entirely bizarre protest claiming that the conception would lead to the closing of psychiatric hospitals. They both needed the enemy and through very unfortunate statements they made themselves enemies. It was a rather unfortunate formulation which gave the impression that the hospital psychiatrists are to be blamed for the bad conditions in the hospitals as if they were the cause of this curse. There are many excellent people working there, and plenty of interesting initiatives and therapies, and many people were helped in these hospitals. It seems like no one is actually interested in the change. Maybe it is a part of this ‘normalization’ era that everyone has found their place in the world, they settled in and do not want to be bothered anymore. The problem is that when you have no means for realization, the energy will just disappear and the opponents would say it was not worth the effort. Over the years we negotiated with the insurance companies, with the ministry of health, we organized hearings in the senate, everywhere, and everyone agrees – but nothing happens. Everyone is tired by now, and no one is interested anymore... Therefore I do not expect any significant changes either.”<sup>68</sup>

Dr. Pavel Baudiš, who was for several crucial years the representative of the Psychiatric Society for the Ministry of Health, comments on the whole process:

“We attempted to do something about the system from below but it did not work at all. We met with absolute indifference. The indifference of politicians, health care administrators, the indifference of the public. We organized several hearings in the Senate, for example, and only one or two Senators would come... We came with the proposal on the reform of psychiatry, currently we are working on the revisions. The

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<sup>68</sup> Dr. Zdeněk Bašný, interview December 2007

aim is to strengthen the care in the community which is currently only rudimental. There are maybe twenty of such organisations providing different forms of care, all of them NGO. The state did not get involved at all. Our other aim was to transfer some of the care from large psychiatric hospitals to psychiatric wards in regional general hospitals, but these hospitals do not want to have any psychiatric wards because that is economically unprofitable. No one is interested in that, and the government says: well, we are aware that psychiatry is under-resourced, we give you more once you do the reform, but how can we do a reform without resources and the authority to do so? In other countries they did the reform from above, adopted new laws, adjusted the system of health care. We are trying to change it from below but it just does not work because it clashes with all the indifference above.”<sup>69</sup>

At the end, the representatives of the Psychiatric Society itself came to the conclusion that the system of psychiatric care is not, after all, their responsibility: their mission is clinical care and research, not health care policy. Its president Professor Jiří Raboch recounts on their official website a story that illustrates well the position of the society has taken with respect to the state:

“I had a call by the editor of an important national newspaper recently. She asked me whether I am aware that in one of the regions there is significant lack of psychiatric hospital beds. In a rather harsh tone she conveyed her conviction that it is a failure of the Psychiatric Society under my leadership. I advised her that although our conception document clearly states that there is a need for more hospital services, we are neither the organizers of health care – which is the Ministry of Health – nor its providers – which is the Ministry of Health and the local authorities – nor the payers – which is the health insurance companies – and therefore we have no responsibility or liability for the accessibility and quality of mental health care.”<sup>70</sup>

He continues with a list of the activities of the Psychiatric Society in the area of academic research and international collaboration that he considers a priority, and also reviews the history of the project of ‘the conception of psychiatric care’ and the unsuccessful attempts for its implementation and concludes:

“We attempted to contribute to the improvement of quality of provided care and enforce the interests of our profession. We organized several meetings with politicians and with representatives of our payers. We also announced a National Psychiatric Program, accepted formally by the Ministry of Health of the Czech Republic. The crucial steps for the development of psychiatric care are the

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<sup>69</sup> Dr. Pavel Baudiš, interview February 2007

<sup>70</sup> Professor Jiří Raboch, 24.3.2010 [http://www.psychiatrie.cz/index.php?option=com\\_content&view=article&id=235:kdo-jsme-co-chceme-co-meme&catid=1&Itemid=11](http://www.psychiatrie.cz/index.php?option=com_content&view=article&id=235:kdo-jsme-co-chceme-co-meme&catid=1&Itemid=11)

responsibility of the organisers, providers, and payers of health care. Our unified consensual attitude should serve as grounds for their decision making.”

The official statement of the society emphasizes their role as an expert, academic and professional body, and clearly renounces any form of social or political responsibility.<sup>71</sup>

In 2000, two of the representatives of the presidium – professors Cyril Höschl (who later served as a President of European Psychiatric Association) and Jan Libiger – advocated this narrow understanding of psychiatry as a strictly scientific medical discipline, emphasizing the academic expertise and renouncing any social involvement as a potentially illegitimate practice extending beyond their mandate in democratic society:

“Medical science provides theoretical knowledge and models necessary to understand human disease and cure it effectively. ... Psychiatry as a medical discipline relies on the authority of medicine that is associated with help to a suffering and deserving individual. If this source of authority is obscured in psychiatry, the discipline will be blamed for serving as a social tool for controlling undesirable phenomena and practices. ... Psychiatry is subject to political abuse due to its special position among medical disciplines, overlapping with the social sphere. Once its original purpose is obscured, psychiatry takes on a responsibility far beyond its scope, involving some political aspects that it cannot legitimately hold in a democratic state. So we should carefully guard the boundaries of psychiatry to prevent its abuse in the future.” (Höschl et Libiger 2000)

One of the factors that might have attributed to this prevailing attitude is that the Psychiatric Society is traditionally led by academics whose interest is in their research and academic activities and who consider it almost an abuse of psychiatry to be involved in health care policy. These academics do not held themselves responsible and accountable for the state of psychiatric hospitals – where they do not work – and mental health care provision in general – about which they seem to care little about.

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<sup>71</sup> No one from the representatives of Czech Psychiatric Society (Professor Raboch, Professor Höschl and several others I approached) was willing to find any time to speak with me replying they are too busy (they mostly indicated research or various European projects, if they replied to my emails at all). I was therefore unable to get their perspective firsthand. However, I did interview Dr. Pavel Baudiš, its president in the 1990s.



From the other side of the debate I encountered several psychiatrist who expressed their discontent with this position of Czech Psychiatric Society. Dr. Ivan David rather bitterly commented on this:

“It is a question of scope what is actually meant by psychiatry. Psychiatry as medical science is a rather different issue than psychiatry as care for those who suffer from mental illness. As one famous physician said: ‘medical science is a wonderful science – if only the patients were not so annoying’. While you sit in the library or pipette some blood samples or examine the slices of brain, psychiatry is a wonderful science. Only it does not really help the ill, who can snuff away from thirst and hunger while you do not need to care!”<sup>72</sup>

Dr. Pavel Baudiš who worked in the area of psychiatry for more than fifty years and even in his retirement continues to be actively involved comments on the current situation:

“Psychiatry has always been marginalized and always will be – as I used to say it is the anus of medicine. Current tendency of extending the limits of psychiatry does not always do good. All these advertisements for happiness, promoting the idea that psychiatry can make you feel better – I sometimes think that once a year the executives of all pharmaceutical companies in the world must meet and decide on a new diagnosis that they will promote. Once it was a hidden depression, then a social phobia, they always easily find something. They have a great influence and power and the psychiatry obediently carries out their plans. Nevertheless, whenever you expand in one direction you have to contract somewhere else. The resources for psychiatry are then directed somewhere else than where the need is greatest. We would have enough work to do with all those who are severely ill, in addition to the care for the elderly, for alcoholics, drug addicts... All of them are currently in large institutions even though if many of them would be able to live with some support elsewhere, in communities with less demanding schedules. They would not degenerate the way they do in these institutions. The large hospitals certainly have their place in the system but they are not the best solution for everyone. You see it in California where they closed down many of the large hospitals and not too much later they had to reopen some of them because there was no alternative to take care of these people otherwise. Or in Italy, where consequently the numbers of homeless people but also prisoners increased significantly.”<sup>73</sup>

The Czech Psychiatric Society recently invested instead into their visibility on the international scene: from the presidency of European Psychiatric Association,

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<sup>72</sup> Dr. Ivan David, interview December 2007

<sup>73</sup> Dr. Pavel Baudiš, interview February 2007

to hosting international conferences in Prague: the WPA World Congress of Psychiatry, World Congress of Biological Psychiatry, the European Congress of Psychiatry, World Congress of Social Psychiatry. As one psychiatrist critically remarked, the nice facade often conveniently hides the inside – which is as true of the beautiful hospital complexes in large parks as of the scent of self-importance filling the atmosphere of conference lobbies.

A significant amount of the activities of the society's most prominent academic figures goes toward collaboration with pharmaceutical companies who currently fund almost all postgraduate education in psychiatry and various research project and are the main sponsors of the (often rather extravagant) meetings and conferences of the Society. Czech Republic became a popular site for conducting a clinical trials and these are considered prestigious projects to participate on (Petryna 2009). Some of the most prominent figures of Czech psychiatry even run private foundations and charities offering service to pharmaceutical companies, using their professional authority for promotion of corporate interests.<sup>74</sup> Rarely they realize that by this they contribute to the 'funneling' of public goods, so pivotal for any possible reform they argue for, into private profits. The promotion of self-interest is certainly not unique to psychiatry but is symptomatic of the whole post-socialist society after the initial intoxication of freedom slowly evaporated and allowed for more pragmatic approach. Tony Judt, a prominent historian of Central Europe remarks on this:

“As anyone who has traveled or lived in post-Communist eastern Europe will know, the transition from repressive egalitarianism to unconstrained greed is not attractive. There is no shortage of people in the region today who would enthusiastically second the view that the point of political freedom is to make money. Certainly this is the

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<sup>74</sup> Academia Medica Pragensis, 'dynamically evolving company specialised in providing marketing and other services for pharmaceutical industry, medical societies, state institutions and non-governmental institutions' by professor Cyril Höschl, the Director of Prague Psychiatric Centre and former president of the European Psychiatric Association, for example ([www.ampra.cz](http://www.ampra.cz)). He did not have time to be interviewed, although we were communicating about this issue via email – rather ironically, he asked me to draft Conflict of Interest Policy for the European Psychiatric Association which he was asked to write, which I did. It appeared as Cyril Höschl, Lydie Fialová. European Psychiatric Association Guidance on the Conflicts of Interests. In: European Psychiatry 27 (2012): 142–146. Professor Jiří Raboch, the President of Czech Psychiatric Association received an award for his Contribution to Congress Tourism from the Mayor of Prague in 2011 (he also has family connections to a private company that was hired to organise all above mentioned congresses). Despite several attempts he never replied to my emails asking for an interview.

view of President Václav Klaus of the Czech Republic – and he is not alone.” (Judt 2011, p. 146)

It might be incorrect to attribute the failure of the reform to pursuing private interests. However, the primarily economical priorities of the post-socialist transformation (in the words of Václav Klaus, prime minister and then president, ‘first money and then all else’) clearly contributed significantly to the indifference or even disregard of needs of those most vulnerable. The psychiatrists who were in close contact with their patients recognised their vulnerability quite clearly and initiated the discussion and attempted to make the problem visible in the public arena. However, the official leadership of the Psychiatric society gradually adopted the view that after all it is the state’s responsibility and there is no reason why they should be responsible for the current state of affairs, and the initial critique was gradually silenced. Although some of the initiators still try to mobilize the public through their blogs, public lectures and newspaper contributions, most just mind their own business.

The criticism of the position of the Psychiatric Association from the initiators of the transformation of psychiatry has continued in recent years. The key disagreement revolves around the question of who is actually responsible for the wellbeing of patients. As an example of this I provide excerpts from the 2010 open letter exchange between the Czech Association for Mental Health represented by Dr. Martin Jarolínek and the Czech Psychiatric Society represented by Professor Cyril Höschl (who until recently was also the president of European Psychiatric Association), published on the website of the Czech Psychiatric Association.

“Dear All,

The largest part of the responsibility for neglecting the development of modern community care that would do justice to the needs and rights of psychiatric patients is to be attributed to the Czech Psychiatric Society. As a professional society it should aim for the best attainable provision of psychiatric care in the Czech Republic and to be a main partner for negotiation with the Ministry of Health, the Ministry of Social Affairs, members of parliament and senators. It is essential to terminate the long standing neglect of the needs and rights of psychiatric patients and prepare well and prudently the transformation of the system of psychiatric care in the Czech Republic. Therefore we appeal to the Czech Psychiatric Society to:

Immediately commence with the revision of the proposal for the transformation of the psychiatric care, including setting specific goals, implementation plans and their timing.

Do the utmost to put pressure on all relevant authorities to implement this proposal immediately after its completion.

Put significant pressure on the Ministry of Health which promised to collaborate with other sectors to transform the services for mentally ill patients (while nothing happens).

Collaborate with the National Council for the Disabled in the CR and their working group on the legislation for the protection of rights of mentally ill patients.

Put systematic pressure on the Ministry of Social Affairs to create a new legal incentive to allow mentally ill patients to receive social disability support.”<sup>75</sup>

The Czech Psychiatric Society dismissed this complaint by arguing that the Proposal for the Transformation of Psychiatric Care (that paradoxically was initiated by Dr. Jarolímek and his colleagues) reflects differing opinions on the roles of professionals and other representatives of civil society:

“Your appeal regarding the termination of the longstanding neglect of the needs and rights of mentally ill patients and the preparation for the responsible transformation of psychiatric care in the Czech Republic is entirely justified and we believe that majority of the providers do identify with this. In this respect, your letter is an attempt to break through doors which are already open. It is the Czech Psychiatric Society that constantly works towards the creation of the conception of psychiatric care and provides the opportunity for all interested parties to participate.”<sup>76</sup>

The letter continues with accusations on a personal level arguing that the authors of the open letter are not partners with the Psychiatric Society in this endeavour and that they potentially misrepresent their own personal opinions as the position of the Czech Association for Mental Health Care. Professor Höschl also reproaches Dr. Jarolímek for offering criticism instead of productive collaboration or providing alternative proposals through professional representation as well as political negotiations with the Ministry of Health and Ministry of Social Affairs in the name of the Association that represents ‘civil society’. The Psychiatric Society perceives

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<sup>75</sup> <http://www.psychiatrie.cz/images/stories/spolecnost/dopis-CAPZ-10-02.pdf>

<sup>76</sup> <http://www.psychiatrie.cz/images/stories/spolecnost/odpoved-CAPZ.pdf>

itself as a neutral arbiter and emphasizes its professional and expert advisory role for the Ministry of Health.

The arguments rehearsed in these exchanges touch ultimately upon the very fundamental question of who is responsible for caring for those who as a result of their illness are unable to provide for themselves. This responsibility is negotiated between families, communities, the professions and the state and the new socio-political circumstances opened up renegotiation of appropriate roles of each of them in the context of a democratic or civil society. Where the family is absent it is left to local communities and the structures of the state to take on the responsibility. However, because of the miserable conditions of state provided care in psychiatric sanatoria it was the psychiatrists who saw the patient's needs insufficiently addressed most closely. The psychiatrists who were trying to fulfill their professional roles and duties towards their patients and at the same time took on more engaged role as fellow citizens of their patients, advocating on their behalf, ended up in divided and conflicting positions that lead to the fragmentation of their professional community. Dr. Pavel Baudiš commented on the whole situation:

“There is a lot that nobody really knows how to deal with, and so they pass around the responsibility from one to another. The politicians do not care. The psychiatrists did a lot of work but then exhausted themselves by their own power-struggles, and insist on extreme positions. The psychiatric wards of general hospitals do not accept difficult patients and just send them around from one institution to another when they don't know what to do with them, and so they all end up here, in the large hospitals. All the people whom others disposed of end up here, and the conditions here are not easy at all. It reminds me of the movie *Fat Berta* by Charlie Chaplin where they are supposed to fire from a cannon and it does not work – the explosives falls down a few meters from the cannon and keeps smoking, and nobody really wants to deal with that. The general turns right to his deputy, the deputy turns right to his deputy, and it continues like that through the whole row, and the last in the row is Charlie Chaplin and he also turns right – but there is none there anymore.... So everyone disposes of their responsibility because this responsibility is nothing to envy about.”<sup>77</sup>

These conflicts and unclear division of responsibilities between the parties involved eventually paralyzed the whole process of change. The psychiatric

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<sup>77</sup> Dr. Pavel Baudiš, interview February 2007

profession was weakened by inside-rivalries and unable to mobilize the necessary resources on a political level. The indifference of the state represented by the Ministry of Health and Ministry of Labour and Social Affairs in this case was not sufficiently challenged and they were not held accountable in any way for neglecting its responsibilities and duties towards patients as citizens.

However, it is worth remembering that it was exactly the indifference of the state authorities that led to the initiative of the psychiatrists in the early 1990s. Throughout the following two decades these psychiatrists realized that despite their best attempts they were in no position to change the system and as their inter-profession disagreements and conflicts grew their position weakened, their initiative slowly evaporated, and their interest either transformed into resignation or the pursuit of other projects. The impulses for social change lost their momentum when confronted with the blindness and indifference of the economic forces and incompetence of the power structures of the state. Despite being well intentioned to emphasize the urgency, the symbolic association of large hospitals with totalitarian power and democracy and civil society with community services had rather unfortunate consequences. The disagreements and bitter hostility within the professional community to which these contributed which further weakened their ability to exercise pressure on the existing power structures.

An important factor in the failure of this endeavour was thus the unclear division of the roles and responsibilities of the profession, state, and civil society at large under new sociopolitical circumstances. The individual psychiatrists acted as advocates and activists on behalf of their patients – which came to conflict with their allegiance to the profession as an instrument of the state. The curious historical legacy of the relationship between the professions and the state during socialism (Hoffman 1997), the indifference or even neglect of the state that pursued more urgent priorities of economic transformation, and the failure to mobilize resources of civil society contributed to the impotence of these initiatives. The movement for reform in psychiatry certainly bear traces of their origins in the apolitical understanding of politics and even their practical implementation through primarily

informal networks of interested people was grounded in this tradition. However, this was not sufficient to mobilize political power which was ultimately necessary for any thorough change of the complex system. The new political circumstances which made possible but also critically required more engagement with the official political and professional sphere paradoxically contributed to the failure of this project.

## **The Historical Paradoxes of Ideologies**

The attempt to improve psychiatry in the early 1990s was not the first such effort in the recent history. After the communist party took power in 1948 there was a comprehensive reform of health services in the early 1950'. For the first time, in 1958 the Ministry of Health included psychiatry among its priorities and provided resources for this reform. One of the most significant steps was the introduction of a large network of outpatient psychiatrists and the establishment of psychiatric wards in general hospitals to provide care for patients closer to their home in medical therapeutic environment. The psychiatric sanatoria treated both acute psychiatric conditions and provided long-term hospitalization (the average hospitalization time dropped from 262 days in 1955 to 190 days in 1962). The need for more qualified personnel was perceived as a key priority. However, there were clear limitations to the attempts to recruit more nurses and other paramedical staff:

“The lack of interest in nursing among men – for which they are paid less than for work in industrial enterprises – was partially solved by employing female nurses even in departments for male patients. Also the participation of psychologists in the diagnostic and therapeutic process under the control of physician greatly increased the quality and efficiency of the treatment” (Prokůpek et al. 1968, p. 132)<sup>78</sup>.

This reform also affected the training of psychiatrists of which there was significant lack of immediately after the war (there was one physician for 160 beds in 1949 and their number increased to one physician for 53 beds by 1963). In 1955 the Psychiatric Department of the Postgraduate Medical Training Institute was established on the premises of Bohnice hospital with the remit to train a new generation of psychiatrists. As more psychiatrists became available, and also because the recently developing pharmacological treatments whole new form of outpatient care was being introduced for patients who were previously dependent on

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<sup>78</sup> This is a long standing issue – even today there are only very few male nurses for similar reasons, and there are actually fewer psychologists available since they gained access to more prestigious and better rewarded work in the private sector after 1989.



care in the large hospitals.<sup>79</sup> The outpatient psychiatrists' offices also employed a nurse and a social worker to help the psychiatrists look after their patients and visit them in their homes.

Writing in 1967 for Ari Kiev's book on Psychiatry in the Communist World that was published in New York in 1968, three psychiatrists – Josef Prokůpek, Jaroslav Stuchlík and Stanislav Grof – provided an account of the current state of psychiatry. Some twenty years after the war and possibly also under pressure to show the compassionate face of socialist society they recount the various initiatives that were carried out to improve psychiatric care. They observe that *“because very little therapeutic activity occurred previously [hospitals] have been thought of merely as the ‘last resort’ for the patient”* (Prokůpek et al. 1968, p. 127). Contemporary advances in psychopharmacology – chlorpromazine and reserpine were introduced into clinical practice in Czechoslovakia in 1955 – also significantly changed the spectrum of conditions treated in the hospitals. The enthusiasm for pharmacotherapy – which in retrospect seems to be rather overstated – is evident from the following account of the authors:

*“As was the case in other countries, the ataractic era effected a revolution in mental hospitals. Their basic character underwent a substantial change: today patients with psychomotor excitation and aggressive manifestations cannot be found in the wards and beds with protective nets and isolation rooms are no longer necessary. Even the patients in psychotic wards have become more socialized and the overall outlook of many wards does not basically differ from departments for somatic patients. Grilles have gradually disappeared from the windows of mental hospitals and open-door policies have been introduced in many pavilions.”* (Prokůpek et al. 1968, p. 140).

The authors recount the post-war development of psychiatry and the reform proposal of 1953 where a group of ‘progressive psychiatrists’ elaborated a program for psychiatric care. They argued for: better outpatient care and the prevention of mental disease through the continuous development and improvement of inpatient facilities; the necessity of training new physicians and paramedical personnel; the exploration of new methods of therapy, rehabilitation, and resocialisation for

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<sup>79</sup> However, it is also important to note that well into the 1950s a significant proportion (estimates are up to 60%) of hospital patients suffered from untreated neurosyphilis and tuberculosis and the advent of antibiotics had a groundbreaking effect on the profile of patients cared for in the psychiatric hospitals.

psychiatric patients; an emphasis on outpatient services including day and night hospitals and sheltered workshops; and specialised services for the treatment of alcoholism. Their conclusion has a rather victorious tone:

“In Czechoslovak psychiatry generally there is a trend toward treating the greatest possible number of patients as outpatients. Mental hospitals have undergone far-reaching change toward the humanization and socialization of the milieu and also towards a more human approach with patients. Last but not least, much effort is directed toward the popularization of modern psychiatric knowledge with the aim of eradicating prejudices in the lay population against the mentally ill and of alleviating their condition after dismissal from psychiatric facilities. ... The vision of Purkyně was brought forth at the time of the suppression of the Czech nation during the capitalist era, but it can become a reality in the contemporary conditions of our socialist society.” (Prokůpek et al 1968, p. 142; 128)

Of course, the parallels between this reform effort and that of the 1990s are evident: in the 1950s, as in the 1990s, a proposal for improvement followed a change of political system, associating the poor conditions with the past regime and proposing change in line with the new orientation or ideology. In addition, the authors’ perspective on post-war Czechoslovakian psychiatry in 1968 – a time of relative liberalization but nevertheless still deep in the Cold War era – shares some characteristics with my informants’ accounts of the early 1990s. The change of political regime after the war – which these psychiatrists apparently welcomed with enthusiasm allowed them to express their deep dissatisfaction with the practices of the previous regime and embrace a more humane and progressive approach to psychiatry.<sup>80</sup> Associating the unsatisfactory practices with the pre-war government, they discuss additional improvements in line with the new orientation or ideology –

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<sup>80</sup> In the preface to the book, Ari Kiev attributes not only the theories and practices but also the occurrence of a particular disorder to the sociopolitical situation: “*Major psychoses are said to be biologically caused and to be related to the social environment. Minor psychogenic disorders, on the other hand, are thought to be caused by environmental stresses, and the smaller number of these cases and their continuing diminution are explained by the notion that the conflict between the exploiting and the exploited classes has been dissolved and classes have been abolished. Thus, homosexuality and other sexual deviations reported absent in most Communist countries are associated with capitalist morals. In Czechoslovakia, where such conditions are said to exist, they are attributed to residual capitalist influences, in other words, deviant individuals are not proper members of the new society. Other factors said to contribute to the lower incidence of psychiatric disorders are the greater number of women working, the abolition of private property, and good outpatient services, which not only treat patients, but also actively seek out others to treat early in their illnesses and which maintain registers of all patients.*” Ari Kiev (ed.) *Psychiatry in the Communist World*. New York: Science House 1968, p.15

and the ideals to guide the practices in the 1960s and in the 1990s are rather similar. The complaints that the psychiatric hospitals are the ‘last resort’ for patients, the lack of resources for improvement of the environment in the hospitals and the training of the staff, and the lack of community services all continued to resonate in every interview I conducted. Moreover, many of the psychiatrists I encountered voiced a concern that things had actually gotten worse after 1989 and that the accelerated progress clearly visible in other areas of society was completely suspended or even reversed in psychiatry. The dramatic social changes that affected the lives of most of people left the world of psychiatry behind, forgotten, enclosed in walls of indifference. The initiative of the state through which the conditions of the hospitals were indeed improved the 1950s and 1960s was completely absent throughout the 1990s and 2000s. In an era free of any political coercion, the hopes and expectations of the psychiatrists unfortunately turned into bitter disappointment.

This comparison illustrates the complexity of how the theory, practice, and the rhetorics of sociopolitical ideology intersect and constitute each other, how they are used in times of historical rupture to attribute different meanings to the same phenomena – and how difficult it is to dissect them and reconstruct the ‘real’ situation retrospectively.

These earlier accounts of the status of psychiatric care thus problematize the common assertion that the repressive institutions and desperate material conditions are the fault of the communist regime. This association served the purpose of mobilizing public and political awareness of the problem but over time became less convincing as an explanation of the inherited situation. Commenting on the recent history of psychiatric care, Dr. Pavel Baudiš attributes the miserable state of the hospitals rather to the fact that these are facilities and environments where the really dark and difficult states of human existence concentrate:

“The hospitals became rough places, the dignity of patients is trampled, the staff is overwhelmingly burn out – although I insist that this is not due to ill-intention. It is a kind of callousness that people cease to be aware of. The environment and the conditions of the patients affect the staff significantly although you do not always realize that – you are just resigned to that. But you never know. Thirty years ago we were dealing with a complaint – in the past they were using ‘watering’ to calm down

the agitated patients – putting their head under water. Once a patient drowned. We then talked with the director of the hospital he said – ‘well, I thought we do not use this method here anymore’. Who knows – how can you tell what is really going on there? In 1953 the Central Committee of the Czechoslovakian Communist Party ordered an inspection of all psychiatric hospitals, and immediately closed down three of them because of the utterly unacceptable conditions there, and then you have to say, well done, Central Committee! They also decided to strengthen significantly some neglected areas – psychiatry, radiology, forensic medicine – they invested a lot of money and created a comprehensive system of psychiatric out-patient care.”<sup>81</sup>

The attribution of the repressive or ‘inhumane’ practices merely to the communist regime should thus be viewed with skepticism. Although this strategy mobilized resources for reform at a time when the dissociation from the past was an overarching theme of politics and when the motive of liberation resonated well with the symbolism of psychiatry, it did not succeed and, as time went by, this framing slowly ceased to be relevant. The perception of the situation slowly succumbed into overall inertia. The system still works somehow and the situation does not ‘shout to the heavens’ for immediate resolution. Dr. Pavel Baudiš continues:

“The reform in psychiatry was always achieved only when the scandals reached a certain limit as a consequence of some kind of disaster. In Greece on the island of Leros, they discovered an entirely horrible and appalling institution. The patients were running around naked. Nobody cared. They made it into an international affair. The EU released money and transformed the institution into a quite pleasant and hospitable facility. Similar things happened elsewhere. The scandals here are too small and considered too insignificant. Some of the practices get publicized from time to time but it gets smothered quickly before it reaches the point of really causing change.”<sup>82</sup>

Some of the protagonists in the reform of psychiatry thus attempted to take this approach and wake up public awareness and mobilize political resources through publicizing some of the conditions and practices they considered scandalous. This attempt was redressed in a new language that resonated more comfortably within the international discourse in the late 1990s: the notion of human rights. This reframing

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<sup>81</sup> Dr. Pavel Baudiš, interview February 2007. Dr. Pavel Baudiš himself suffered injustice and persecution by the regime so this is certainly not an exclamation of a nostalgic communist. He invited me to interview him in a humble flat in a high-rise building in the suburb of Prague in which he lives with his wife who is a general practitioner. They both continue to contribute to their respective fields while being retired.

<sup>82</sup> Dr. Pavel Baudiš, interview February 2007

of the endeavour that nevertheless must be seen as its continuation shall be discussed in the following chapter.

## **Chapter 3**

### **Human Rights and the Way to Europe**

#### **Human Rights Discourse in Psychiatry**

Psychiatry – perhaps inevitably – tends to be perceived as repressive and in a specific context the images and symbols of restriction, restraints and isolation become persuasive. The presence of these motives in recent cultural history can be traced back to the very origins of modern psychiatric care: the act of Philippe Pinel who removed the chains from the patients in a Paris asylum for the insane during French Revolution in 1789. This imagery seems to awaken in times of social and political upheaval, decrying the past corrupted practices and contrasting them with what is hoped for in a new, more humane era. The demand for the humane treatment of those who are often perceived as being discriminated against and a call for their inclusion in the new society is often present in times of challenge to the political order. In the 1960s some of the leftist public intellectuals and social critics turned to psychiatry as the ‘emblematic’ case of the oppressive nature of society, its distorted norms and institutions. Among the most prominent authors are Michel Foucault, Erving Goffman, Thomas Szasz, and Ronald David Laing.

In a similar fashion this symbolism and rhetorics were used after the fall of Soviet Empire in Central and Eastern Europe. In the case of Czechoslovakia the protest against restriction and repression was associated with the renouncement of the totalitarian regime and the demand for liberty with the political struggle for national independence from the Soviet Empire. The discourse of ‘liberation’ served as a point of radical dissociation with the past perceived as trampling human rights and the autonomy and dignity of the individual. It is not surprising therefore that even the proposed reform in care for the mentally ill was presented as a project of ‘humanization’ of psychiatry, and its aim to ‘bring patients back to the society’. Large psychiatric institutions enclosed within the walls and isolated from the outer world became readily available symbolic resource. In retrospect these initiatives

represent one of many such initiatives resonating with the wider struggle for political autonomy and self-determination. These were attempts to dissociate from the restrictive past of foreign rule and return to the 'community of Europe'.

The human rights initiatives in the area of psychiatry were in the beginning closely linked with the initiatives and proposals for the transformation of psychiatric care. After an initial review of the political abuses of psychiatry in the early 1990s (initiated by psychiatrists) the first initiative explicitly framed in the human rights discourse was the APEL study – an 'audit of rights and ethics of treatment' – in selected large psychiatric sanatoria conducted between 2002-2003. The discourse on human rights allowed the authors to make the case for the rights of psychiatric patients not as *patients* but as *citizens*, as political subjects of the recently reborn democratic state. However, it was still the awareness of vulnerability to injustice from society and social institutions that made the need of legal protection of patients seem of crucial importance, although this reframing did represent a significant shift from arguments based on compassion to those based on entitlement.

By the mid-1990s, human rights discourse became an important resource and instrument for social change. The language of human rights also provided a common platform to both the tradition of Czech dissent and the more individualistic, liberal discourse of Western cultural tradition. Nevertheless, as a result of this fusion the meaning of the concept of human rights has been transformed – from the early emphasis on social solidarity grounded in shared human condition as in the Charter 77 to clearly defined, positive rights, grounded in international treaties and monitored by international agencies. The formulation of 'protection of human rights' used in the early 1990s and concerned with specific individuals or groups of individuals who are vulnerable and threatened has been gradually replaced by 'human rights advocacy' concerned with adherence to abstract rights and following particular techniques of promoting the subject's interests. The 'human rights agenda' became institutionalized within government institutions and non-government organisations, and was negotiated in the context of various international treaties and institutions. Both before and after the fall of communism, human rights initiatives

and activities in Czechoslovakia seem to follow a pattern of dialogue between independent civil initiatives and various international organisations that formulate their aims in terms of human rights. For example, The Helsinki Committee was established by people around the Charter 77 and the Committee for the Unjustly Persecuted and provided the link between the domestic and international affairs in the area of human rights.

In 1991 Czechoslovakia signed the *Convention for the Protection of Human Rights and Fundamental Freedoms* of the Council of Europe and incorporated the *Universal Declaration of Human Rights* into Constitution of the Czech Republic in 1993. In 1998 the government established Council for Human Rights and appointed a Commissioner for Human Rights.<sup>83</sup> Additionally, between 2007 and 2010 the Ministry of Human Rights existed in parallel as an independent government office with special emphasis on civil and political rights, the rights of minorities and foreigners, children and ‘sexual minorities’. Initially, both the Committee and the Ministry offices were held by former dissidents around Charter 77, only in recent years the representatives younger generation of professionals from various NGOs involved in the area of human rights and social exclusion were appointed. These offices issue reports to the Council of Europe on the adherence to the principles stated in the European conventions – for our purposes most importantly the *Convention on Human Rights and Biomedicine* (CE 1997) and the *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* (CE 1987). The Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) inspected several psychiatric institutions and reported on various questionable practices (1997, 2002, 2006, 2008, 2009, 2010)<sup>84</sup>. Of the issues highlighted by the Committee the one that caught the attention of international mass media became the use of cage beds in hospitals and social care institutions. Additionally, several non-governmental organisations were established since 1990 in

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<sup>83</sup> <http://www.vlada.cz/en/ppov/rlp/government-council-for-human-rights-50632/>, <http://www.vlada.cz/en/pracovni-a-poradni-organy-vlady/zmocnenec-vlady-pro-lidska-prava/cinnost/zmocnenec-en-17253/>

<sup>84</sup> <http://www.cpt.coe.int/en/states/cze.htm>



the area of human rights, often with ties to international agencies. By the late 1990s, the human rights discourse was thus well entrenched in the public discourse as well as in governance structures.

In 1999 the Parliament established an independent office of the Public Defender of Rights (i.e. Ombudsman; in Czech the title ‘Ochránce’ literally translates as ‘Protector’) with a special mandate to *‘protect people against the conduct of the authorities and other institutions if the conduct is against the law, does not correspond to the principles of a democratic legal state and the principles of good administration, or the authorities are inactive, and to carry out preventive systematic visits to places where people are restricted in their freedom and seeks to ensure that their rights are respected’*.<sup>85</sup> The first appointed Ombudsman was Dr. Otakar Motejl, a lawyer who during communism as an advocate represented people persecuted by the government (including the Plastic People of the Universe), and served as a judge on the Supreme Court in 1968 and then again in the 1990’, being appointed Minister for Justice in 1998 and Ombudsman in 2000. While in the office, he conducted a thorough survey of adherence to the law in several psychiatric hospitals (2006-2008) and issued a report on the conditions in psychiatric hospitals which outlined many problematic issues found during inspections.<sup>86</sup>

The discussion of human rights of psychiatric patients was also opened in the public media, the first dating back to 2003 when *The Literary Review* published an article entitled ‘Do any violations of human rights of patients occur in psychiatric hospitals?’<sup>87</sup> This article consists of correspondence exchange between Dr. Jan Jařab, then Government Commissioner for Human Rights, and Dr. Pavel Baudiř, the psychiatrists with interest in ethics and law. It was published as a response to the debate on the use of cage beds in social care homes and psychiatric hospitals that has

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<sup>85</sup> <http://www.ochrance.cz/en/>

<sup>86</sup> <http://www.ochrance.cz/en/press-releases/press-releases-2010/otakar-motejl-justice-democracy-and-serving-the-people/>

<sup>87</sup> ‘Jsou v psychiatrických léčebnách porušována lidská práva pacientů?’ Literární noviny, 8. prosince 2003

repeatedly been brought up by several reports of international human rights organisations, most notably by the Committee on the Prevention of Torture in 1997 and 2002.<sup>88</sup> Jan Jařab was one of the student activists in 1989 revolution. Trained as physician, he was involved with human rights issues in the aftermath of the Yugoslavia wars in the ‘Movement for Social Solidarity and Tolerance’.<sup>89</sup> Pavel Baudiř is a psychiatrist who spend almost sixty years of his life working life in psychiatric hospitals and published the first book on ethics of care in psychiatry. In the early 1990s he was president of the Czech Psychiatric Society and director of the department for Social Psychiatry in the Prague Psychiatric Centre.<sup>90</sup> Their discussion in *The Literary Review* was framed in terms of what we, as a society, owe to psychiatric patients. This conceptualization presents a rather interesting perspective on the issue of rights, which assumes certain obligation in terms of social contract, as well as a notion of reciprocity and exchange.

Jan Jařab outlined four main areas where violations of human rights potentially occur: many people who are currently dependent on the hospitals would be able to live more independently in sheltered housing with appropriate support and therefore their liberties are constrained unnecessarily; the procedural rights of patients treated involuntarily are very poorly followed and the process of legal capacity assessment and the appointment of a guardian lacks the guarantee of the protection of the patient; the responsibilities of guardians and even the rights of patients are not clearly formulated and enforceable; and patients are often not treated

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<sup>88</sup> These reports subsequently gained attention of international mass media as a ‘cage beds affair’ where psychiatric institutions in Central and Eastern Europe became especially scrutinized area in the context of international human rights agencies. Human rights law was considered an instrument of change and a strategy for improvement of care in psychiatric hospitals.

<sup>89</sup> Jan Jařab is currently is a Regional Representative for Europe of the UN High Commissioner for Human Rights. He worked in the Commissioner Office to work as a Group Commissioner on Fundamental Rights in the EC office of Vladimír řpidla, Commissioner for Employment, Social Affairs and Equal Opportunities (2004-2010), where he initiated the the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care (2009) and issued a Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care. In June 2011 his UN office launched a report on the rights of people in institutions, entitled *Forgotten Europeans, Forgotten Rights: The Human Rights of People Placed in the Institutions* – [http://europe.ohchr.org/Documents/Publications/Forgotten\\_Europeans.pdf](http://europe.ohchr.org/Documents/Publications/Forgotten_Europeans.pdf)

<sup>90</sup> Pavel Baudiř was also involved in the recently established Ministry of Health Ethics committee, reviewing and responding to the complaints from patients.

well by the staff working in the hospitals and there are no safeguards against such mistreatment. He emphasized the role of law to protect patients and regulate the care. Pavel Baudiš agreed with the role of law for protection of patient. He nevertheless observed that even formal compliance with the law does not guarantee humane practices within the hospitals: the humiliation and injustices that patients suffer are always acts of a specific person working there and therefore more attention needs to be given to cultivate the environment of the hospital itself. When I interviewed him some years later he commented that during the fifty-four years of his service in psychiatric hospitals he has indeed seen a significant improvement of care that has become more 'humane' but that the continuing stigmatization of mental illness, psychiatry, and especially psychiatric patients prevents any substantial change:

"The stigmatization of psychiatry and psychiatric patients is often a barrier for any substantial improvement for their conditions since they are not considered deserving any better. Everyone knows how terribly ashamed the patients feel for their mental illness, how difficult is it for them to find a job, how isolated are they from the society, how many jokes there are about crazy people and how 'schizophrenia' is misused by a common language. The media present rather stereotypical portrayal of people – every day we can read about crimes committed by 'former psychiatric patients' and nobody ever mentions that any award was given to former psychiatric patients – if you look just at the presidential awards, there are quite a few psychiatric patients among them! This is a real stigma, because it is cruel, hurtful and very often gravely unfair."<sup>91</sup>

This interchange of opinion concluded with the agreement that the rights of psychiatric patients is not just an issue for the professional medical community and activists in the area of human rights, but it is something that is in the public interest and needs to be addressed and resolved as such. Both of the authors share the view that the use of cage beds recently brought into attention in international media represented only the tip of the iceberg. In their view, there were many other institutional practices deserving attention and scrutiny. Some of these might be considered a legacy of the past, and they expressed the disappointment with their expectations that in the fourteen years after 1989 revolution we were supposed to move much further toward dignified care for psychiatric patients. They emphasized

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<sup>91</sup> Dr. Pavel Baudiš, interview February 2007

that the collaboration of the profession, state institutions and the public is crucial for any potential reform, but has not been considered a political issue. This collaboration has unfortunately also been undermined by disagreements within the psychiatric profession, by more urgent priorities of the ministries involved and by the limited awareness and interest of the public. Interestingly, they also linked the dignity of patients with the state of the environment in which they are taken care of and which has to be addressed in order to improve their life conditions: *“The dignity of the environment is dependent on sufficient staff, on the architectural, material and hygienic condition – all of which have a significant financial correlate.”*<sup>92</sup>

Soon after his appointment as the Government Commissioner for Human Rights in 2002, Jan Jařab included psychiatry in his agenda and included it in the annual report on human rights for the government and for the Committee on the Prevention of Torture. This was the first step toward establishing the cause of human rights in psychiatry as being of legitimate and significant political concern. He recounts some of the initiatives undertaken while he was in the office:

“I initiated the creation of a department for human rights and biomedicine as part of the Council for Human Rights, as an advisory government committee. We initiated a revision of the civil juridical order regarding involuntary hospitalization and also a revision of the incapacity law – which after an incredibly complicated procedure was passed by the parliament, although in a rather minimalistic form. We also initiated the APEL study – an audit of rights and ethics of treatment – which surveyed some of the most significant problems of psychiatric hospitals. It was aimed to examine not only the use of restrictive measures – highlighted by the net beds affair – but also the area of autonomous decision making, the right to privacy, the possibility to raise complaints, and the level of openness to the outer world. Retrospectively I do not think I made any significant conceptual contribution but I could possibly claim some merit for the diplomatic aspects – I was able to bring radical reformers together with the apologists for the status quo and through patient and persistent persuasion bring them to a consensus that enabled us to move things forward a little. For example, the participation of Pavel Baudiř – an expert adviser to the Ministry of Health – meant that the system could not distance itself so easily from the results of the survey.”<sup>93</sup>

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<sup>92</sup> ‘Jsou v psychiatrických léčebnách porušována lidská práva pacientů?’ Literární noviny, 8. prosince 2003

<sup>93</sup> Jan Jařab , email correspondence, 2007

The APEL study to which Jan Jařab refers was a survey conducted in 2002-2003 in four large psychiatric hospitals and coordinated by the Center for Mental Health Care Development, an NGO founded by Jan Pfeiffer in 1995 as an ‘umbrella organisation’ for initiatives in the area of deinstitutionalization and community care. The survey consisted of inspections with interviews with patients and staff, as well as administration of questionnaires. The preamble of the final report makes a rather confident statement of its mission:

“Shortly after the political changes of 1989 the professional and wider public became interested in the status of human rights in psychiatric institutions. The debate of that time centered mostly on the question to what extent was psychiatry misused for political purposes during communism. The Geneva Initiative on Psychiatry in collaboration with the Czech Psychiatric Association organised a nationwide seminar on the rights of psychiatric patients in 1992. The conclusion of these discussion was that political misuse of psychiatry in Czechoslovakia was by no means a massive phenomenon. Being satisfied by this finding the professional public became content with the issue of patients’ rights for some time. In line with the process of strengthening of civil activities, the emancipation of patients and their family members, and with regard to the increasing interest on the status of human rights in the EU candidate countries and above all with the general democratization of our society, the question of the human rights of psychiatric patients has been raised again now in more comprehensive way than was the case shortly after 1989. As a result of this process the professionals devoted to humanistic ideals and others interested in the care for psychiatric patients developed a methodical instrument to survey the current state of adherence to the rights of psychiatric patients in psychiatric hospitals in order to continually improve the state of affairs.”<sup>94</sup>

It was a first such initiative where the issue of psychiatric care was framed explicitly in the terms of human rights and as such was linked to the political context of post-socialist process of democratization. The final APEL report lists findings of practices that are not in compliance with the law and can be classified as a violation of patient’s rights, among which are: the obligation of informing the court about involuntary hospitalization is often delayed; patients are denied access to their medical records; the consent for hospitalization is considered identical with the consent for treatment which often resulted in patients being forced to take any prescribed medication; patients have rather limited possibilities of leaving the ward

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<sup>94</sup> [http://www.cmhcd.cz/dokumenty/APEL\\_I.pdf](http://www.cmhcd.cz/dokumenty/APEL_I.pdf); [http://www.cmhcd.cz/dokumenty/APEL\\_II.pdf](http://www.cmhcd.cz/dokumenty/APEL_II.pdf)

on their own; patients are not informed about their rights and there are no formal procedures in place to raise potential complaints about their treatment. Moreover, in the cases where patients lack legal capacity the role of their appointed guardian is mostly only formal: the guardians often do not have any contact with the patients and therefore can hardly know about their wishes and interest, necessary to be taken into account when acting on their behalf. Also, since patients are not allowed to use their mobile phones their contact with the ‘outside world’ is rather limited. The identification cards of patients are kept by the staff even when patients are on leave and patients receive only a letter that confirms that they are currently treated as inpatients in the hospital (these practices are justified in terms of potential theft in the case of mobile phones and the possible loss of their documents). As a result, whenever the patients are asked to prove their identity on their leave from the hospital it exposes them to shame and humiliation. Additionally, most of the hospitals had no guidelines and documentation on the use of restraints, and there is no systematic review concerning the necessity of their use in particular cases. Some patients also complained about having been restrained as a form of punishment rather than as a measure of prevention, and the cage/net beds are also often used as a preventative measure against falls in elderly patients.

The report also emphasized that most of the hospital buildings are more than one hundred years and even considerable effort spent on their renovation may not make it possible to create a good quality space and environment comparable with general hospitals. The patients often share large rooms with more than six other patients and 11-13 bed rooms are not a rare occurrence either; the premises do not allow privacy in bathrooms and toilets (justified as a prevention of suicide the doors of toilets and bathrooms are missing or left open). The report concluded that the solution for many of these issues is beyond the scope of action by the individual hospitals and require a thorough systematic solution.

The findings of the report did not have repercussions on the political level and the Ministry of Health did not take any steps to act on the recommendations. Nevertheless, the findings were included in Government reports on the state of

human rights for the CPT and other international organisations, and the issues raised by this survey have been reappearing over the years in various reports from the initial inspections of the Committee for the Prevention of Torture in the 1990s to the 2009 report of the Ombudsman office, as shall be outlined later.

## Cage Beds and Civilized Europe

In 1995 Jan Pfeiffer, psychiatrist and one of the most vocal proponents of community care, founded in collaboration with several of his colleagues Center for Mental Health Care Development. It aimed to serve as an umbrella organisation for initiatives in this area and stated its mission to *'help develop mental health care in the Czech Republic in line with the Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care adopted by the UN in December 1991 (UN General Meeting No. 46/119). The principles declare treatment and care for mentally ill patients a basic human right.'*<sup>95</sup> Although the purpose of this organisation can be seen as a continuation of the earlier attempts to transform psychiatry, framing the mental health care debate as an issue of human rights altered the direction of the discussion on the appropriate forms of care in psychiatry as well as the social dynamics of the debate which had significant implications. In contrast to earlier discussions on the transformation of psychiatry these initiatives were negotiated through different channels, used different strategies and later gained a life of their own beyond the psychiatric community. It was also through human rights discourse that the debate over psychiatry acquired an anti-psychiatric edge which resulted in even more polarization and eventually the disengagement of the psychiatric profession.

The reference to human rights in these debates provided a link between the earlier notion of the 'humanization of psychiatry' as a goal of the transformation of psychiatric care in the early 1990s and the current international discourse on human rights. Reframing the arguments for transformation in the language of human rights endowed the discussion with a moral force that transcended the world of the professional community and transformed it into issue of international interest that in the context of accession to the European Union was hoped to exert political pressure on the government 'from the outside'. It was in the context of the overall stagnation of the effort of transformation that the 'human rights scandals' – disclosures of

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<sup>95</sup> <http://www.cmhcd.cz/en/index.html>



unkind and harsh practices in the psychiatric hospitals – were disclosed and publicized by some of the proponents of community care in hope of mobilizing the public and attract international interest in order to facilitate change.

The most notable of these was the ‘cage bed affair’ in which a very specific method of restraint was used for its symbolic power to convey the potentially repressive aspects of psychiatry. This affair was initially was inflamed by Jan Pfeiffer and was taken forward by some of the human rights NGOs working in this region (Jan Pfeiffer was later named ‘Hero of the Year’ by the Time magazine in 2004 for his activism). It was raised in Czech and European mass media on three occasions (2004, 2006, 2008) with the intention of exercising pressure – from both national and international community – on the responsible government bodies to reform the psychiatric institutions. However, the emphasis on restriction and restraint – motives of the anti-psychiatric movement in the West several decades earlier – and the ideological and rather uncritical cause for de-institutionalization seem to have obscured some of the more important aspects of reform that require thorough structural systemic change.

Initially, the main sponsor of the initiatives in the area of human rights in Central and Eastern Europe was The Open Society Foundation (OSF). In 2002 the OSF established the Mental Disability Advocacy Center (MDAC), a Budapest based NGO that aims to ‘advance human rights by using law to promote equality and social inclusion through strategic litigation, advocacy, research and monitoring and capacity-building’.<sup>96</sup> One of the first initiatives of this Center was a study on the use of restraints in state institutions in Central and Eastern Europe, as these were highlighted in the 1999 CPT report alerted the international community on the misuse of restrictive measures in psychiatric and social care institutions in these countries. Jan Pfeiffer explains about the background of this project:

“I was invited to join the Open Society for this MDAC which was initially Soros’s activity. He often comes to a country, issues a report, and makes it a huge scandal, which often complicates things for the poor people who are trying in small steps to move things forward... He issued a report on Hungary in 1997 with a group of left-

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<sup>96</sup> <http://mdac.info/>

oriented intellectuals who then worked in the Mental Disability Rights International – they have done something similar previously in Uruguay, Paraguay... Soros wanted to make this Center a more permanent instrument for change in Eastern Europe. The main instrument was supposed to be the litigation of cases in individual countries and that is what they now do. They have their lawyers who prepare these cases in different countries. Currently they have over twenty legal cases and increasingly they also got involved in monitoring and education as well.”<sup>97</sup>

The MDAC identified the ‘cage beds’ as an evocative and persuasive symbol of the restrictive power of psychiatry that might have the potential to attract international media to report on the abuses of human rights in institutions in Central and Eastern Europe. The origins of the use of cage beds can be traced back to the late nineteenth century when they were first introduced in the Austrian-Hungarian empire and they represent a rather persistent item of material culture in this area. They continued to be used in this geographical area as a preferential form of restrictive measures – preferred over strong medication, bed restraints, straitjackets and isolation rooms – and are still considered more ‘humane’ than these other restriction means as they allow for communication with the patients.<sup>98</sup> The cage beds are of metal construction – a ‘cot bed’ with fencing on the top as well. A variation on this is the ‘net bed’ which has a metal frame and nets covering the sides and the top of the cot (in the course of media campaign there was a lot of discussion around precise definitions and distinctiveness of these two types with the net beds generally being considered more acceptable than cage beds).

Cage beds were therefore specific enough to the Central and Eastern European region as the heir states of the late Austrian-Hungarian empire. These countries were at that time in the application process for admission to the EU, where one of the significant conditions to be met was the compliance with human rights principles and standards as these were perceived as key values of the European community. Cage beds therefore became an ideal instrument to bring the ‘violations

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<sup>97</sup> Dr. Jan Pfeiffer, interview January 2008

<sup>98</sup> Many of the psychiatrists I interviewed noted that the use of restraints, isolation rooms or strong medication is in some cases unavoidable to calm down agitated patients. However, their use must be extremely carefully justified and closely monitored. A comparative study on the use of coercive measures in EU countries was conducted in 2002-2006 as a European Evaluation of Coercion in Psychiatry and Harmonization of Best Clinical Practice – <http://eunomiastudy.net/>

of human rights' in these countries to the attention of the world. The results of the MDAC study entitled 'Inhuman and Degrading Treatment in Four EU Accession Countries' were presented at the EU Parliament in Brussels in June 2003 and from there made it into an international press as a political issue.



Bed with nets, Kosmonosy hospital 2007

As a response to this report several members of the European Parliament wrote a quite clear and straightforward letter addressed to Zdeněk Škromach, then minister of Labour and Social Affairs in the Czech Republic. It was initiated by John Bowis, MEP, who was previously involved in this area as part of Geneva Initiative on Psychiatry.<sup>99</sup> The letter unequivocally condemned the use of restrictive tools and since the wording is intentionally strong I include part of it here:

“The use of restrictive measures cannot be considered a legitimate component of medical treatment and has been denounced as inhuman and degrading. We, as members of European Parliament, concur that this practice is a violation of fundamental human rights and must be abolished. It is incumbent upon the government of the Czech Republic to take measures to put an end to this inhuman and degrading treatment of those living in institutions. Testimonies of individuals placed in cage beds reveal that people felt ‘like animals’ and experienced fear, shame and humiliation. We condemn the use of such barbaric tools in the strongest terms possible. People with mental disability are among the most vulnerable and disadvantaged groups in all societies and the protection of their human rights deserves our utmost and immediate attention. While comprehensive policies and legislation is needed to ensure that the human rights of people with disabilities are fully protected in all European Societies, the eradication of cage beds is a first step the Czech government must take to show its commitment to such goals.”<sup>100</sup>

The accession of Czech Republic to the EU was planned for 2004 and this letter was thus supposed to elicit immediate and resolute response on the site of the accession states. What was the response of Czech government, then? The Ministry of Health asked Jan Pfeiffer as a well known proponent of human rights to provide a response to this criticism – a criticism which he himself originally stirred through his NGO – of which the Ministry of Health was unaware. Jan Pfeiffer comments: “*It was rather absurd, you write a critical report and you are asked to write an official response to this critical report*”.<sup>101</sup>

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<sup>99</sup> John Bowis was involved in the Geneva Initiative on Psychiatry – later renamed as the Global Initiative on Psychiatry – which collaborated with Jan Pfeiffer’s CMHD on some earlier projects in this area <http://www.gip-global.org>

<sup>100</sup> Letter from 10 July 2003, addressed to Mr Skromach and signed by Liz Lynne, MEP; John Bowis MEP; and Richard Howitt MEP, cc to Dr. Marie Součková, then minister of healthcare.

<sup>101</sup> Dr. Jan Pfeiffer, Interview January 2008

This international criticism nevertheless provided an incentive for a Senate hearing organised by Jan Pfeiffer and his Centre for Mental Health Care Development in collaboration with the Czech Psychiatric Society, who hoped to bring the issue to the attention of Czech politicians. It was entitled ‘Do we belong to Europe with respect to the quality of care for the mentally ill? Destigmatization and the transformation of psychiatry in the Czech Republic’.<sup>102</sup> In fact, this was already a second Senate hearing, following on the one organised in 2001, and John Bowis from the Geneva Initiative on Psychiatry delivered a keynote entitled ‘The World Condemned Large Institutions’. However, apart from Petr Pithart, signatory of Charter 77 under whose auspices the seminar was organised, only one other senator turned up. This was quite accurate reflection of the lack political interest in this issue.

Several well established international experts were invited to give a talk at the Senate hearing, among others Norman Sartorius from the WHO and Graham Thornicroft from the Institute of Psychiatry. Jan Pfeiffer’s speech on this occasion was entitled ‘*To Europe or Back to History*’ and he suggested:

“We find ourselves at a crossroads and we need to decide whether we shall continue with the stigmatization of the mentally ill and their exclusion from the society or remove the burden of the past. It is a political decision and it is important that politicians are able to hear the message, that the humanization of psychiatric care is a passport to civilized Europe.”

To make their case more convincing, the representatives of the CMHD brought a cage bed to the Senate and asked one of their patients, Michal Celetka, to give a testimony of his experience of being enclosed in this bed for several days.<sup>103</sup> The invited journalists did not hesitate to disclose information from his documentation to which he himself was denied access, and this all made a perfect story for international media. The report on cage beds was broadcasted by BBC in July 2004. It quoted Michal Celetka comparing the cage beds to a ‘cage in a ZOO, like a small prison’, and concluded that cage beds do not belong in a civilized

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<sup>102</sup> In fact, this was already a second Senate hearing, following on the one organised in 2001, and John Bowis from the Geneva Initiative on Psychiatry delivered a keynote entitled ‘The World Condemned Large Institutions’.

<sup>103</sup> [http://www.bbc.co.uk/czech/domesticnews/story/2004/07/040713\\_cz\\_cage\\_2130.shtml](http://www.bbc.co.uk/czech/domesticnews/story/2004/07/040713_cz_cage_2130.shtml)



society.<sup>104</sup> However, Celetka's testimony was dismissed by some of the psychiatrists present in the audience as inaccurate and 'very subjective'.

Around the same time The Sunday Times published an article entitled 'The Ordeal of the Caged Czech Children' based on story of an undercover Sunday Times reporter who posed as a prospective social worker and carried a concealed camera during three visits to a Children's Home in Ráby. In addition to a vivid description of her experience she offered images that portrayed the cruelty of carers who keep children locked in their beds. The article reported that the disclosures prompted condemnation from medical and legal experts and a demand for urgent reforms from a senior British member of the European Parliament: Baroness Nicholson, MEP, explicitly labeled these practices as torture and the inmates (the children) as torture victims: *"I am gravely troubled by this medieval cruelty and I intend to champion the rights of these torture victims at the highest levels in Europe and in Britain. Now that this has been brought to the world's attention, it has to be stopped immediately."*<sup>105</sup>

It seems that the terminology for the violation of fundamental human rights and torture was used without any further scrutiny of the extent and form of the actual practices in psychiatric and social care institutions in the Czech Republic. The references to barbarism and backwardness of the region were also used to frame what could be considered a cultural difference in calming practices into an asymmetrical moral standing between the West and the East of Europe.

The authors of this 'plot' soon got unexpected support from an unusual source. After reading the Sunday Times report on the children in social care institutions, the author J. K. Rowling wrote a letter to Czech President Vaclav Klaus, prime minister Vladimír Špidla and several other government officials – as well as to politicians in the UK and EC – to bring attention to this 'inhumane treatment of institutionalized children'.<sup>106</sup> (The Sunday Times entitled the article that appeared a

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<sup>104</sup> [http://news.bbc.co.uk/1/hi/programmes/crossing\\_continents/3873123.stm](http://news.bbc.co.uk/1/hi/programmes/crossing_continents/3873123.stm)

<sup>105</sup> <http://www.timesonline.co.uk/tol/news/uk/health/article445266.ece>

<sup>106</sup> <http://news.bbc.co.uk/1/hi/world/europe/3891189.stm>

week later ‘Rowling’s quest to halt child torture’).<sup>107</sup> Surprisingly, it was only at this point the affair became reported by Czech media.<sup>108</sup> Newspapers suddenly filled with images of Harry Potter miraculously redeeming innocent children from their horrible fate. J.K. Rowling emphatically commented: *“children in cages experience more horror than Harry Potter fighting evil.”*<sup>109</sup>

The director of Bohnice hospital, Dr Ivan David, bitterly returned the offense: *“Czech psychiatry has rather different problems than Ms Rowling thinks. Maybe she should rather attend to the fact that according to statistics almost eight percent of the elderly in the UK are abused by their relatives.”* Similarly, one of the nurses working in the social care institution from which the BBC report was filmed disagreed with the framing of the practices in terms of human rights abuses: *“This criticism is deeply and seriously offensive. I wish Mrs. Rowling came to serve one night shift here and she will know better. I have a daughter at home who suffered from epilepsy and these beds are the only way to protect her from harming herself.”*

Nevertheless, as a response to J.K. Rowling’s letter, Jozef Kubinyi, then Minister of Health, immediately banned the use of the cage beds in hospitals and promised the net beds would disappear by the end of the year. The President Václav Klaus invited a representation of eight psychiatrists to the castle to discuss the issue. It was a rather noteworthy choice: the experts in psychiatry were those considered responsible for this practice – not the policy makers and representatives of the Ministry of Health. At this point the discussion centered merely on the use of restraints and the professional expert reasons why psychiatrists consider net beds

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<sup>107</sup> <http://www.timesonline.co.uk/tol/news/uk/health/article456569.ece>

<sup>108</sup> The following quotations are translation of what appeared in various Czech daily and weekly newspapers and magazines, such as Lidové noviny, Mladá fronta DNES, Hospodářské noviny, Respekt, Reflex.

<sup>109</sup> J.K. Rowling commented on her website: “In July 2004 I read a newspaper report that horrified me, regarding the use of cage beds for mentally handicapped children. As a direct result of that piece, I became one of the founding directors of a charity called the Children's High Level Group, which campaigns for the protection and promotion of children's rights.” [http://www.jkrowling.com/textonly/en/links\\_cb.cfm](http://www.jkrowling.com/textonly/en/links_cb.cfm) Jan Pfeiffer, who gained international recognition when Times Magazine declared him an ‘European Hero’ of 2004 for his human rights activism, after working few years as a consultant in community mental health in Southern England, was offered a position in this foundation of J.K. Rowling and Baroness Emma Nicholson to work on the de-institutionalization of children in Central and Easter Europe ‘on the highest political level’. The foundation has since been renamed Lumos – <http://wearelumos.org/>

‘more humane’ than other forms of restraint – such as high doses of sedatives, bed restraints or isolation rooms. One of the doctors present mentioned a survey conducted among psychiatrists asking them which of the measures would they find most acceptable if they once find themselves demented, anxious, agitated – where the net beds came out as the first choice.

The invited psychiatrists insisted that although psychiatry has to deal with patients in agitated states that indeed require some form of restraint – and do so even in the most civilized countries in the world – the restriction as such is not the main issue of psychiatry and there are many more aspects of care that indeed have more significant implications for the wellbeing of the patients. Although all invited psychiatrists agreed that the problem of cage beds is rather marginal compared with other major issues in psychiatry, especially the critical lack of staff and resources to provide adequate care of the patients as well as the outdated material conditions where large numbers of severely ill patients have to share one room, the meeting clearly did not involve any discussion about political responsibility for the larger problems of the conditions of the hospitals.

The director of one of the largest psychiatric hospitals in Dobřany, Jaroslav Žižka, commented: *“Whereas the money spent on one patient per day is 900 Kč in Czech hospital, the European average is between 30 000 and 40 000 Kč, and for a patient whose condition requires the use of net beds they have three nurses. The problem is not in the state of psychiatry – which is quite comparable with other European countries – but in the flow of finance.”* And the director of Kosmonosy hospital, Dana Kolářová, added more prosaic point to the debate: *“Half of the net cages we use are replacements for regular beds and we have to use them since we have no money to buy new ones.”*

This affair was feeding the media for a while with exchanges of very different opinions. Some psychiatrists commented that every child spends part of their childhood time in similar beds and therefore it is quite natural to use them for children who need special protection from their self-destructive behaviour as well as for adults who need to be protected of potential self-harm for similar reasons. It is the



therefore the patient's condition that is disturbing, not the use of beds: *"Of course it looks like the patient suffers greatly in the bed, but unfortunately this is a symptom of his conditions that he looks like that. He would look the same outside of the bed as well, this is his normal state, his disability."* Zdeněk Bašný, director of Bohnice hospital recalled that while they were clearing the net beds from the hospital they were approached by parents of mentally disabled children who wanted to buy these beds for their homes: *"It is true that the bed is not esthetically pleasing, and for that reason I even assigned an architect with a task to design a bed that would be both practical and esthetically acceptable. However, we did not find anyone who would manufacture this and who would be willing to pay for it."*

These comparisons were nevertheless criticized by then Ombudsman, Anna Šabatová (again, one of the Charter 77 signatories) as debasement and a distraction from the violations of human rights that indeed occur in hospitals and social care institutions. This opinion resonated also in other media articles resolutely expressing similar sentiments, such as *'Human being does not belong to the cage'*, and concluding that the use of net beds dehumanizes people who are then living 'like animals'.

The debate also gained a slightly defensive nationalist edge: several newspapers commented that although net beds are also used in neighbouring Austria – which happens to be a western European country – without any unease from the international community, the Czech Republic is portrayed as a country where 'we torture our patients'. German Professor of psychiatry Tilman Steinert confirmed the net beds are indeed used in Austria since it enables better communication with the patient than is the case with other restrictive measures. He also said that different European countries have different preferences what the use of restrictions concerns and we should consider this issue of cultural practice rather than ethics.

As an official response, the prime minister Vladimír Špidla replied to Mrs. Rowling by explaining the nature of these restrictive measures:

*"Net beds are beds that serve the sole purpose of the protection of the severely mentally disabled and psychiatric patients suffering from serious mental condition as*

well as for their surroundings. Patients are in these beds only for a necessarily limited time needed to bring their acute state under control. I categorically refuse the accusation that Czech medicine or psychiatry is not comparable with other developed countries. We have issued guidance that allows for the use of the restrictive measures only in exceptional circumstances when the life and wellbeing of the patient is under serious threat or when they threaten others – but always for the benefit of the patient.”

The response of Václav Klaus also emphasized the ‘technical aspects’ of restrictions and defending the national reputation in his response letter he wrote to J.K. Rowling:

“Dear Mrs. Rowling,  
Thank you for your letter in which – on the basis of one accidental, non-serious article in the British press – you objected to the use of so called net and cage beds for mentally handicapped children in the Czech Republic and asked for a ban on their use. The problem you touched upon is, of course, important and is an object of permanent, earnest, and expert review in our country, as well as elsewhere in the world. ... The issue of using particular restrictive means, as well as the overall regime for handicapped patients in medical institutions has its moral and ethical aspect, but the arguments of medical experts are equally important. It is impossible to simply shift the argument to the issue of abiding or abusing human rights. It is necessary to carefully evaluate the use of restrictive means in the treatment of individual patients. It is also necessary to find appropriate methods of preventing mentally handicapped people from injuring or mutilating themselves or others. Neither the Czech expert public, nor myself, can accept your radical and extremely simplified opinion caused by an emotive and very tendentious article. The Czech Republic is a standard democratic country and our health care is comparable with the health service of other advanced countries. I must refute the idea that the use of the aforementioned beds is abusive, or worse, that mentally handicapped children are tyrannized in our country. It would be likewise possible to criticize the placement of handicapped patients in special rooms or their sedation by increased doses of medicine. All restricting methods have their benefits and drawbacks, and the attempts at fix-all solutions would only cause new problems, new complications and further discussions. ... Thank you for your interest in these problems and for your contribution to our domestic discussion on this topic.”

Václav Klaus then invited to his office Jozef Kubinyi, the Minister of Healthcare, and reproached him for submitting to the emotive pressures and criticized his prohibition of the use of cage beds as a ‘cheap and populist gesture’ that was in deference with expert opinion. Dr. Kubinyi was also criticized by both professional and general public for the rash solution that was not supported by any

evidence of real misuse, and later he penitently acknowledged that the timing of his ban was rather unfortunate “*since it might have been understood as a confirmation that in the Czech Republic we commit some serious iniquities in dealing with our people.*” Kubinyi was recalled from his ministerial post few weeks later.

In contrast to the Ministry of Health, the Ministry of Labour and Social Affairs – which is responsible for residential social care institutions where these beds are used for mentally disabled children and adults and therefore was equally guilty of these practices – invited experts from Northern Ireland to teach their Czech colleagues to use ‘techniques that do not violate human rights’ and appointed a ‘good practice group’ who worked systematically on issues of restriction in social care institutions.<sup>110</sup> This working group in collaboration with experts from the Netherlands and the UK developed thorough training programme for staff to manage the aggression of clients without sedatives and net beds.<sup>111</sup> This group also continued their work on the ‘Conception for transformation of residential social care in other forms of care’.<sup>112</sup>

When I asked Lucie Rybová, the secretary of the Committee Against Torture and Committee for Human Rights and Biomedicine at the Government Council for Human Rights, how she explains this difference in response between the Ministry of Health and Ministry of Labour and Social Affairs, she provided rather blunt opinion: “The people there are more humane. There are more enlightened people at the Ministry of Labour and Social Affairs. They made this new law. They were willing to see that it is possible to do this otherwise and they suggested that in the law. It is nevertheless interesting that both of these ministries were dealing with the same problems and used the same argument – that if they had more carers, more staff, it would be possible to deal with this issue otherwise. This means that this is not an issue of medical or professional expertise, but it is a financial and capacity issue, no doubt about that. The Ministry of Health also said, yes, if we had more staff we can do this otherwise, but they have done nothing at all to change that. There are also not

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<sup>110</sup> This debate was also reported by Lancet in September 2004 (364: 829-830), following their 2002 report ‘Mental Health Care still Poor in Eastern Europe’ (360: 552), and later again in 2006 as ‘Czech Government to be Sued over Caged-Bed Death’ (367: 1889).

<sup>111</sup> The net beds were taken from the list of restrictive measures by an amendment of the Social Care Act in 2005 and allowed for use only in extremely limited cases when the life of elderly clients might be in danger.

<sup>112</sup> [www.mpsv.cz/files/clanky/2694/110406.pdf](http://www.mpsv.cz/files/clanky/2694/110406.pdf)

that many experts there, only Mrs S., who is responsible for complaints in the area of psychiatry. All the experts in psychiatry who were consulted about that they were supportive of the use of net beds – which was not the case with social care where they even initiated a group of good practice which is now examining how their clients are treated.”<sup>113</sup>

Commenting on the whole affair, Dr. Zdeněk Bašný, then director of Bohnice hospital who currently works in private practice and directs the Bona foundation observed:

“We expected that something would happen, since the campaign of international organizations who were interested in the cage and net beds was going on for some time. These initiatives were led by amazing, enthusiastic young people, supported by other enthusiastic people. However, none of them has ever worked with severely mentally ill. Although it is attractive for the media, it does not resolve any of the main problems of Czech Psychiatry. No one ever comes to see in what conditions are we practicing, how overcrowded we are, that we have to keep our patients in these massive hospitals – patients that could be elsewhere with additional support – without having adequate personal and technical equipment for that. Our patients will not have these beds anymore, but for some it might mean worsening the quality of their life that is already miserable enough. Indeed, we can use bed restraints for someone who is in an acute state – but for some this is a lifelong state.”

Again, he emphasizes that some states of agitation or aggression are symptoms of mental illness and need to be addressed somehow. Dr. Bašný continues with his argument:

“We could certainly increase the sedatives as we were recommended, or we can put them in protected isolation room as we are advised by the Brits. They might lay there, talk, but they would be there alone. But even severely disabled people need the company of someone else, of someone alive. The bed protected by the net enables them to have this company. It might seem that they do not even sense or feel the presence of one another, but that is not the case. Of course, the net or the grids should not be a barrier that would isolate them from others, they need to be spoken to, cared for. Feed them, change the diapers, close the grids and come back in five hours? In no case this should happen. But how can you care well, working twelve hours shifts and having two or three nurses for wards with 60 patients who require not only observation but also assistance? Of course you can also have staff that seem nice and pleasant but who actually do not like the patients and considers them inferior, which

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<sup>113</sup> Lucie Rybová, interview January 2008

the patients do sense quite acutely. I think this is much more serious issue than all of the cage beds together.”<sup>114</sup>

Having enough resources is thus necessary but not sufficient condition of humane and compassionate care. Similar opinion was expressed by Jan Jařab, the human rights commissioner:

“The main roots of our problems are over-dimensioned institutional care, insufficient developments of alternative forms of care (i.e. community care and ‘half way’ care), insufficient finances for needed reforms and the will for systematic solutions. ... One of the expression of all this might be the overuse of restrictive means – not only net beds but also use bed restraints, and above all medication – sedatives, that are doubtlessly much more dangerous. ... It is much more serious issue that we treat disabled people as things, without compassion, without providing necessary stimulation and without respect to their privacy. ... This media storm misses the very essence of the problem: from the variety of restrictive means the one that is probably the most sensitive to the patient is selected and charged with an emotionally effective impression. I wish that this media scandals would cause system solution but I am afraid that it would only turn into a red herring in debates about what is a cage and what is a net. The potential ban on net beds without the change of the other circumstances will not solve anything and might even mean the worsening of the whole situation that is already miserable enough. All of this has a social and economical context, namely the shortage of qualified staff in institutions that many decades ago were intentionally located in rather remote areas. ... Therefore instead of only criticizing we need to aim for permanent control by the Public Defender of Rights and support good practice, better financing of care, alternatives to institutional care, and dispersion of large and remote institutions into smaller, more humane ones that are more integrated into society.”<sup>115</sup>

In an article entitled ‘A Psychiatrist is not an evil wizard’, another psychiatrist, David Holub, then chief physician of a psychiatric hospital, responded:

“Anything in the world can be misused and therefore even the psychiatric services should be under public control. It should nevertheless not be limited to the surveillance of respect for patient’s rights, continual monitoring of provided care by truly independent institutions and compliance with rules of conduct with agitated patients. Of primary importance is material support, training and supervision of all the staff in hospitals and institutions. We cannot pretend that states of agitation, anxiety and aggression do not exist, and frown on people who have to deal with this

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<sup>114</sup> Kauza snad alespoř přitáhne zájem úředníků [Affair would hopefully attract the attention of bureaucrats]. Lidové noviny, 17. července 2004

<sup>115</sup> Paní Rowlingová a klece na děti [Mrs, Rowling and Cages for Children]. Magazín Dnes 22.7.2004 – 29/2004

‘dirty stuff’ in the wards. Critical commentaries of ‘anti-psychiatry’ oriented defenders of patients rights are very convincing and impressively humane. However, they are also incredibly cheap. They falsely assume that aggression does not exist and if we treat each other nicely we do not have to deal with violence. The most expressive and evocative description of someone in delirium who is pulling out their infusion tubes or in extreme agitation cannot substitute for the actual experience. ... Do the images of nets and cages evoke memories of totalitarian practices? Do the psychiatric hospitals and social care institutions represent the last reserve of the totalitarian regime which we have to deal with uncompromisingly? Maybe Mr. Kubynyi intended to anticipate these accusations when he banned the use of restrictive measures. However, I consider the disposal of net beds from psychiatric wards as rather unfortunate and alibi solution. The impact on the dignity of the patients we could possibly assess only with the passing of time. Nevertheless, those who as a result of their illness become temporarily agitated or aggressive would not be eligible to be admitted in our wards. They might have to be transferred to some other retaining institution or would have to be sedated by inappropriately high doses of sedatives, which would hardly allow them a more dignified overcoming of the illness state. To be honest, I am not sure whether Mrs Rowling is convinced – based on news reports – that in our institutions evil carers and their victims recreate a fantasy world. Nevertheless, I am thankful that she brings up to the light the immensely demanding work in these institutions. I deeply appreciate the work of nurses and aides who are exposed to extreme situation of hopelessness, who despite the feelings of powerlessness do not leave their jobs. If we can describe something as ‘inhumane’, it is the conditions of their work. The complete absence of adequate support, finances, training, and staffing. If Mrs Rowling would find enough courage to visit us, maybe she would be amazed how little inhumane treatment she would have found in psychiatric hospitals. These findings would nevertheless be much less interesting and appealing in comparison to the tortures Harry Potter receives and also the tortures of others that he watches her books.”<sup>116</sup>

The ‘cage beds’ affair not only moved the debate about psychiatric care in various rather unexpected directions but also seemed to keep attention away from the desperate living conditions in psychiatric hospitals, focusing the discussion instead on the technical aspects of using restraints – as well as on mounting a national defense against international criticism. Although several of the psychiatrists initially expressed their hope that this affair would at least finally attract the interest of the government officials and policy makers to the pressing issues of conditions in psychiatric hospitals, they very soon realized that apart from the criticism they were not offered any solution. This media affair nevertheless contributed significantly to

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<sup>116</sup> Lidové noviny 165/XVII

the growing hostility of the various sections of the psychiatric representations. Precisely because of the choice deliberately emotionally charged symbolism – remote, dark institutions full of cages – this affair also intensified the polarization and tensions between advocates of ‘institutional’ and ‘community’ care. ‘Human rights abuses’ proved to be a rather powerful instrument – or even weapon – in the battle over the transformation of psychiatry. People working in quite miserable conditions in the hospitals became identified with the ‘institutional culture of mechanistic paternalism inherited from the past regime’, as Jan Jařab puts it. The response of the psychiatric representation understandably turned into self-defense – not dissimilar to the political response as national self-defense. Moreover, psychiatrist became very suspicious of the intentions of the human rights activists. As Ivan David writes: *“Yes, psychiatry indeed is abused. Not by psychiatrist, though, but because it substitutes non-functional social care, serves journalist manufacturing affairs, and financially interested human rights craftsmen activists opportunity for their existence. It is not about human rights, it is about money.”*<sup>117</sup>

In retrospect this mixture of despair, compassion, sensationalism and ideology seem to have done little to bring about any significant change for individual patients – some of whom I encountered during my fieldwork four and six years later, and with some of whom I communicated through the nets safely delimitating the space between me and them. The media brought these issues up once or twice since then usually related to some more noteworthy event – J.K. Rowling’s complaints about the Czech President (2006) and a death of a young patient in Bohnice who suffocated on her own feces in a cage bed (2008) that was intended to be brought to the European Court of Human Rights in Strasbourg.

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<sup>117</sup> False game on human rights in psychiatry, 2007 Bohnicke listy, 18-21

Various human rights organisations continue to rehearse the arguments and employ litigation strategies to disclose the abuses of human rights in psychiatry.<sup>118</sup> However, for many involved in this area the whole cage bed affair represents a ‘false game on human rights in psychiatry’ that unfortunately does not really target the root of the problem: the social and political indifference to the fate of those who by virtue of their illness require treatment in psychiatric hospitals. The more urgent priorities of economic transformation seem to have obscured the very reasons why the totalitarian regime was renounced for the lack of respect to individuals, their dignity and rights. Michal Kocáb, the minister of human rights commented in 2010 that in a way this approach is a repetition of what the country witnessed for the last forty years: *“The Bolshevik first looked after the economics, and only then human rights. It must be the other way round.”* And finally, the ambition to belong to Europe and share its values has slowly changed into silent renouncement of the assumed superiority of the Western countries which can dictate conditions for those who want

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<sup>118</sup> More recently, two cases were indeed brought to the European Court of Human Rights in 2013. The project on human rights in psychiatry was taken on by several human rights NGOs, most notably the Czech NGO ‘The League for Human Rights’, and the Budapest based ‘Mental Disability Advocacy Center’. These NGOs are run by young and enthusiastic lawyers whose strategy is the litigation of individual cases in wider European Forum, especially through the reports to the Council of Europe and the European Court for Human rights in Strasbourg. Their advocacy on behalf of the patients slowly gained a more anti-psychiatric tone as they focused on the restrictive practices in psychiatry, culminating in two legal suits against the Czech Republic. The first related to a young patient treated against his will and restrained, and the Court found violations of Article 3 of the European Convention of Human Rights regarding inhuman and degrading treatment (treatment and investigation) (No. 37679/08; <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-113812>). The League for Human Rights considered it a great victory and issued a public comment: “The decision of the Court illustrates the dismal situation of Czech Psychiatry. Thousands of people are annually locked into large psychiatric hospitals, where their rights for individual freedom and privacy are infringed upon, and where their physical integrity and dignity is violated. This decision underlies the need for reform of psychiatric care in the Czech Republic. The first step towards this reform according to the League is the adoption of the plan for full transformation, on which all interested parties, including patients, should fully collaborate.” (<http://lhp.cz/2012/10/strasbursky-soud-pacient-psihiatricke-lecebny-v-brne-byl-podroben-nelidskemu-a-ponizujicimu-zachazeni/>) The second case regarded patient who was claimed incompetent and was treated in psychiatric hospital against his will (no. 23419/07; <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-114658>). His guardian, who agreed with such treatment, was the municipality of Brno – which previously applied for the removal of his legal capacity. The Court found the violation of Articles 5 (right to liberty and security) and 8 (right to respect for private and family life), and implied that where the patient disagrees with his treatment the decision should rest with the court and not with the guardian.

This was the first successful attempt to use the legal provision of the Convention on Human Rights to bring the practices in psychiatry under international scrutiny, and classify them as infringing upon fundamental human rights. The pragmatics of the human rights bureaucracy in the EU are thus helping to change the landscape of human rights in the Czech Republic. However, although both patients were granted compensation there was no further action from the state to examine and rectify potentially widespread practices.



to be part of their ‘private club’ (Judt 2010, Chapter XXII). The concerns about those most vulnerable slowly fell into oblivion.

## Forgotten Europeans

In 2007 I attended a debate organized by the Czech Psychiatric Society entitled '*Psychiatric Legislation: Does our legislation protect our patients, staff, and the society enough?*' Among the invited speakers were medical doctors from psychiatric hospitals and NGOs, representatives from the Office of Government Council for Human Rights and the Office of the Public Defender of Rights, as well as several groups representing the patients. The debate addressed various issues that were in the air since the early 1990s: the legal protection of people with psychiatric illness, the issue of informed consent and involuntary treatment, the continuity of care across the system – from general practice through community and hospital care; various interpretations of 'dangerousness to oneself or someone else' and their implications for treatment; issues of confidentiality and access to medical documentation; collaboration of clinicians with courts; the loss of legal subjectivity and the role of guardianship; the competence and responsibilities of professionals and institutions, as well as the debate on the transformation of psychiatric care and the need for a comprehensive mental health law. The mental health law was first mentioned in the 1990 Manifesto of the Czech Society for Mental Health with the timeline of one year. However, within the professional community there has been persistent disagreement over whether these issues need to be addressed by a specific law or whether they should be included in the general health care law that was being repeatedly revised ever since 1990 – but the new version actually never passed (the Czech Republic is still using the amended 1966 Act on Care of Health of the People, 20/1966). The amendments of 1992 concerned the introduction of comprehensive health insurance, and although several other laws were under debate the comprehensive health law did not find its way through politically divided parliament. There was a confident hope that mental health law would finally make all the good ideas for improvement of lives of the patients somehow enforceable – since the issue of enforceability and accountability seemed to be the dead end of all previous debates.

It was also hoped that the Government Office for Human Rights established in 1998 might provide a mechanism to prevent discrimination against the vulnerable population through its collaboration with other government office. Indeed, Jan Jařab and others included psychiatry as an area of concern. However, Lucie Rybová explains the possibilities and limits of this office to facilitate any significant change:

“We have included the issue of the rights of psychiatric patients in the 2005 Report on the State of Human Rights, but the Ministry of Health is busy with other more important and complex issues, and therefore they keep postponing dealing with it. The government changes every now and then – although in the Government council for Human Rights we are actually in quite a good position to deal with that because human rights do not care whether the government is left or right. We are experts on human rights and despite this universality our positions are sometimes challenged as social-democratic. Our recommendations should not be seen as political. When the government fails in some respects our task is to say that there is a problem – and of course they do not like it. So what happens is that sometimes the official position is that something is not happening (i.e. violations of patients rights) but being involved in the field I know very well that it actually is happening. Then I am posed with a dilemma – should I say this as an official statement: we have this problem and we have to deal with it, or say that we do not have such issues. Because if we do, we as the Czech Republic can be sued for not complying with the treaties, not abiding with human rights. The choice is then whether you rely on internal mechanisms, or whether you let it go externally. Of course we would like to rely on internal mechanisms, and if we bind ourselves we need to invest effort and finances. It would be more honest to just abdicate from the treaties than to have all of these conventions and principles which we do not comply with.”

This dilemma whether to rely on ‘internal mechanisms’ of the state or use the ‘external mechanisms’ of the international community kept repeating over the years. There is an interesting similarity as well as contrast of these initiatives in the area of human rights and the initiatives of Charter 77 some thirty years earlier. The strategy of the initiators was quite similar: bringing the human rights infringements and abuses to the attention and scrutiny of the international public and by their pressure force the government to address these. However, it proved to be a very different situation to criticize the totalitarian regime in contrast to the government elected democratically which is supposed to represent the interests of the society. The understanding the totalitarian regime as imposed externally by force seemed to be

more acceptable than assume that the neglect and indifference is an inherent characteristic of the society long after the totalitarian regime was gone.

While in office as a Commissioner for Human Rights, Dr. Jan Jařab also initiated in 2003 an amendment to the law on role of the Ombudsman which extended the Ombudsman's mandate to include 'protection of person restricted in their freedom' and authorized him to perform preventive systematic inspections to institutions and places where persons restricted in their freedom are or may be confined, in order to *'ensure that their fundamental rights are respected and strengthen their protection against maltreatment.'* In addition to prisons, police cells, military institutions, asylum facilities, educational and social care institutions it also extended the authority to health care institutions. The amendment of the law came into effect in 2006 and the first visits were conducted by Dr. Otakar Motejl and his office in 2008.<sup>119</sup> Psychiatric hospitals were second on the list of institutions visited by his office – after nursing homes for long term patients – and as his secretary informed me, they focused on the material conditions and legal regime in the hospitals. The final report was submitted to Parliament in late 2008, and several institutions were inspected again in 2009 to evaluate the implementation of the recommendations.<sup>120</sup>

As a response to a wide variety of situations and practices in social and health care institutions raised as human rights issues the amendment to the Ombudsman's mandate also included a broadened definition of what constitutes mistreatment:

"Mistreatment is generally perceived as any conduct that fails to respect human dignity. According to the extent of interference with human dignity or in fact physical integrity, mistreatment may take the specific form of torture, cruel, inhumane or degrading treatment or punishment, disrespect for a person and their rights, disrespect for their social autonomy, privacy or right to participate in the process of making decisions that affect them, or misuse of dependence on care provided, or its intensification. In formal terms, mistreatment may not only consist of

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<sup>119</sup> Additionally, Czech Republic ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment and appointed the office of the Defender as a 'national preventive mechanism' in 2006. [http://www.ochrance.cz/fileadmin/user\\_upload/ochrana\\_osob/2009/2009-PL\\_nasledne.pdf](http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/2009/2009-PL_nasledne.pdf), p.1

<sup>120</sup> It is noteworthy that in the English translation of the reports the psychiatric hospitals are being referred to as 'mental homes'.

infringing fundamental human rights guaranteed by the Charter of Fundamental Human Rights and Freedoms or international treaties, or of breaking laws and lesser regulations, but also of failure to fulfill more or less binding instructions, directions, or possibly treatment quality standards, support and care, good practice or procedures required by the profession.”<sup>121</sup>

In this amendment the concept of mistreatment is rather expanded in scope, and although still defined in terms of infringement of fundamental human rights, it expands beyond the notion of harm to include omission of respect to the dignity of the other person. This position derives from the principles of human rights in the natural right tradition where neglecting to respect the other is directly equated with causing harm. This approach is reflected in the report from the inspections of psychiatric hospitals:

“The Defender did not ascertain treatment that could be labelled as cruel or even torture. However, he ascertained cases of formal detention and the performing of interventions with only formal consent of the diseased and also without consent, cases of a dehumanised regime in departments and an undignified environment for treatment. As for material conditions, the Defender stated that the internal environment of the visited departments is, with a few exceptions, very unfortunate and undignified. The technical condition and design of the departments are the reason for many regime limitations: they aggravate supervision over the patients; the latter have impaired access to leave the premises; the departments for agitated patients are not separated from the other departments; small group therapy cannot operate due to the state of decay of the buildings. There are established regimes of rules and prohibitions without support in the legal regulations which are often justified by organisational rather than therapeutic reasons.”<sup>122</sup>

While the report notes the practices employed in psychiatric care, it also focuses on the institutional and material circumstances that are seen as a conditions for the possibility of adherence to human rights. The report discusses issues of space and the internal environment of the hospitals, organisation and distribution of patients in different wards, living conditions for patients as well as working condition of the staff. A large section of the report is devoted to respecting the rights of the patients in different areas such as: admission, voluntary and involuntary

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<sup>121</sup> <http://www.ochrance.cz/en/protection-of-persons-restricted-in-their-freedom/legal-and-key-documents/consisting-of-systematic-visits/>

<sup>122</sup> [http://www.ochrance.cz/fileadmin/user\\_upload/zpravy\\_pro\\_poslaneckou\\_snemovnu/Reports/Annual\\_2008.pdf](http://www.ochrance.cz/fileadmin/user_upload/zpravy_pro_poslaneckou_snemovnu/Reports/Annual_2008.pdf), p.65-66

hospitalization; informed consent; use of restrictive measures where the defender demands the “*legality of these measures and the compatibility of their use with human dignity as well as providing mechanisms to eliminate the potential of misuse.*” It also addresses issues of privacy and dignity related to the administration of restrictive measures and questions their use as both protection and restriction. The right to privacy is also examined in the issue of hygienic standards of bathrooms and the possibility of closing them, communication with physicians, regulation of the daily schedule – the possibility of going for walks, wearing their own clothes, not limiting smoking and the number of cups of coffee and the time of their consumption, the possibility of using their bedrooms during the day, the availability of public phones, not imposing age limits on their visitors, and providing them with shopping. The final aspect discussed is the right of patients to raise complaints.<sup>123</sup> However, despite the emphasis on the environmental and material conditions, it is acknowledged that even improvement of these does not guarantee the necessary respect and demands for comprehensiveness and continuity of care:

“Even the highest quality psychiatric care does not as such provide for dignified life of a person with mental illness. ... Many of the psychiatric patients do not have any provision of housing or required social support after their discharge. As was emphasized at the meeting of representatives of the European national preventive mechanisms and by experts in psychiatry, inappropriate discharge from the hospital can potentially significantly harm the patient. Any current legal provision cannot satisfactorily answer the legal obligation of any particular [legal] subject to take care of patient who is to be discharged from health care institution. ... The organs who would to a certain degree be held responsible for mentally ill patients after they are discharged from psychiatric hospital are nonexistent. No time limits are stipulated to assess the inconclusiveness of their social situation.”<sup>124</sup>

The report discusses in detail the overall organisation of the care of mentally ill and notes the unclear delegation of responsibility between state and local authorities – essentially a side effect of decentralization and partial privatization of

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<sup>123</sup> <http://www.ochrance.cz/ochrana-osob-omezenych-na-svobode/zarizeni/zdravotnicka-zarizeni/psychiatricke-lecebny/zprava-z-navstev-psychiatrickych-leceben/>, report from September 2008 [http://www.ochrance.cz/fileadmin/user\\_upload/ochrana\\_osob/2008/SZ\\_psychiatricke\\_lecebny\\_08.pdf](http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/2008/SZ_psychiatricke_lecebny_08.pdf), and the report on subsequent visits in 2009 from November 2010 [http://www.ochrance.cz/fileadmin/user\\_upload/ochrana\\_osob/2009/2009-PL\\_nasledne.pdf](http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/2009/2009-PL_nasledne.pdf)

<sup>124</sup> [http://www.ochrance.cz/fileadmin/user\\_upload/ochrana\\_osob/2009/2009-PL\\_nasledne.pdf](http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/2009/2009-PL_nasledne.pdf), p. 18

health care in the 1990s – and the critically insufficient finances as well as fragmented legal regulation of the provision of all contribute to the unacceptable state of affairs. The report notes that it is unclear who is actually responsible and accountable for the conditions of the hospitals that represent both medical and social care institutions: *‘The Defender perceives as urgent the miserable situation of patients whose needs require both health care and social care services. The question of who is responsible for providing dignified life of these people is not answered by any legal provision.’*

In the final section of the report the Ombudsman appeals to the following institution and bodies: the Ministry of Justice to institute legal measures to protect the rights of the patients, the Ministry of Health to improve the material conditions of hospitals, to take overall responsibility for their patients, to draft a conception of psychiatric care and negotiate with psychiatrists and health insurance companies; the Ministry of Labour and Social Care to actively collaborate with individual regions to improve network of social care services; and finally the regions to commence concrete solution for the situation of their mentally ill in their districts. Individual hospitals are also urged to actively collaborate with social care providers and regional councils for the improvement of situations. The Defender required the reports on the implemented measures from all these institutions by June 2009.

How effective was this attempt to initiate the improvement? In the follow-up report published in 2010 the Defender discusses each of the issues raised by his visits and outlines the steps taken by individual institutions and organisations, some of which rectified their issues partially, some entirely, and some not at all:

“With respect to the urgency of the situation due to findings of mistreatment in psychiatric hospitals (especially long term patients, long term restrained patients and patients with mental disabilities) the Defender formulated requests to the Ministry of Health and regional councils to respond to this report by informing him on steps taken to remediate this situation. Ministry of Health did not respond at all and as a central organ of state administration in the area of health care did not contribute to the improvement of situation, and since September 2008 did not take any concrete steps to respond to the recommendation of the Defender. The Defender appeals again to the Ministry of Health and that with respect to current legislation the practices common in institutions in the whole Czech Republic is in conflict with the

Constitution of Czech Republic and international conventions that they bounds themselves.”<sup>125</sup>

The silence of the Ministry of Health all this time is striking. One factor to which these shortcoming is attributable is that at Ministry of Health there is not a single person whose agenda is psychiatry and mental health care. The incompetence of the Ministry of Health can be additionally attributed to its being the most unstable ministry – with 17 different ministers in the past 22 years – and the priorities of the economic transformation overshadowed all other concerns. Despite signing several international documents committing to the reform of mental health care there was no systematic approach to implement these policies.<sup>126</sup> Also, there is no systematic collaboration with the Ministry of Labour and Social Affairs despite the significant overlap of concern between health care and social care services. In this situation, even the Office of the Defender lacks the power to enforce the recommendations they issue.

It therefore seems that all these efforts stumble against the invisible wall of indifference while issues that are more critical to resolve immediately are prioritized. Change thus seems to proceed only very slowly as a collaboration between individual professionals and institutions, NGOs, and sometimes regional governments. Despite the shortcomings and limitations of the legal regime, the professionals of various backgrounds I encountered still firmly believed in the potential of the legal framework to ensure that the institutional practices of care are in line with the principles of human rights – not only to deal with specific cases of questionable practices but also as an instrument of systemic change. The legal framework would clearly state who is responsible and accountable for the provision of care – a responsibility that is currently dispersed throughout the system – who provides the finances and who has the mandate to hold the respective institutions accountable for their practices.

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<sup>125</sup> [http://www.ochrance.cz/fileadmin/user\\_upload/ochrana\\_osob/2009/2009-PL\\_nasledne.pdf](http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/2009/2009-PL_nasledne.pdf), p. 11

<sup>126</sup> Among others the Health 21 (WHO, European Region, 1998, Target 6 on Improving of Mental Health, ratified by CR in 2002); Green Paper on Mental Health in Europe (EC 2005); European Declaration on Mental Health, and Mental Health Action Plan for Europe (WHO 2005).



The project of human rights in psychiatry was later taken at the European level through offices in Brussels to which some of the Czech activists were appointed. Dr. Jan Jařab left his government office in 2004 to serve in the EC office of Vladimír Špidla, Commissioner for Employment, Social Affairs and Equal Opportunities, as a Group Commissioner on Fundamental Rights (2004-2010). At this point the discussion over the deinstitutionalization of social and healthcare facilities was clearly framed as a human rights issue. Jan Jařab initiated the 'Ad Hoc Expert Group on the Transition from Institutional to Community-Based Care' with appointed representatives of various European advocate groups, chaired by Jan Pfeiffer. In 2009 this group issued a report which was prefaced by Vladimír Špidla:

"Across the European Union, many people spend long years in institutional care. Some of them have physical or intellectual disabilities, others suffer from mental health problems, and yet others are elderly and frail. There are also many children in institutions, both with disabilities and without. For decades, the existence of such institutional care was seen as proof that society cares, that it does not leave vulnerable persons without assistance and that it provides the needy with food, shelter, clothing and treatment. But is this indeed the best possible model which advanced European societies can offer to these people in the twenty-first century? I am convinced that in an age when non-material aspects such as human dignity, autonomy and inclusion in the community are increasingly recognised as being of paramount importance, European societies should aim for more humane, person-centred, individualised models of care. The users themselves and, where applicable, also their families should become partners and take part in all decision-making. Everyone should be enabled to reach their full potential."<sup>127</sup>

In this report the community care is uncritically related to 'inclusion' the same way the institutional care is related to 'segregation' and 'exclusion'. The ideological association of institutional care with the totalitarian regimes of the latter half of the twentieth century – however not entirely accurate from the historical perspective – has been used strategically as a symbolic resource to mobilize resources to achieve large-scale social change in countries of Central and Eastern Europe. The language of human rights was used to serve similar purpose as it represented the current international discourse and promised to capture the interest of

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<sup>127</sup> <http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=614&furtherNews=yes>

mass media in the international stage. The expectation that the ‘external mechanisms’ might bring change raised new hopes – but also renewed old skepticism about the power of external institutions to cause internal change.

In June 2001 Jan Jařab was named the UN Regional Representative for Europe of the High Commissioner for Human Rights in Brussels, and continued to work in this area. His office issued a report on the rights of people in institutions entitled ‘Forgotten Europeans, Forgotten Rights: The Human Rights of People Placed in the Institutions’.<sup>128</sup> It is focused especially on countries of Central and Eastern European countries who are somehow belated in the cultural processes that the Western European countries undergone in previous decades. The discourse of human rights thus continues to dominate the debate over the appropriate forms of care in Europe. However, not necessarily are the outcomes tangible in the particular settings that have initially raised a cause for concern.

The discourse of human rights that increasingly permeated the discussion on transformation of psychiatry shifted the original emphasis on rights as responsibilities of others, and thereby allowed the actors to reframe the debate in a language that allowed for the reception of mechanisms and institutions developed in Western liberal tradition. Nevertheless, in many respect this discourse proved to be insufficient to mobilize the expected change and in many ways rather proved to be a counter-productive strategy as it obscured the structural problems and subsequently contributed to the hostile polarization within the professional community that initiated the effort to reform of psychiatry. The improvement of the material conditions of the hospitals, practices of providing care, and setting up more accessible community services were identified as necessary for respecting human rights. However, better material conditions of the institutions and closely monitored practices are necessary but not sufficient conditions: on their own these do not guarantee the adherence to the principles of respect for individual patients and their needs in the everyday life. The legal framework of human rights cannot reach the

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<sup>128</sup> [http://europe.ohchr.org/Documents/Publications/Forgotten\\_Europeans.pdf](http://europe.ohchr.org/Documents/Publications/Forgotten_Europeans.pdf)

space of individual encounters and eradicate practices perceived by the patients as humiliating.

As Tobias Kelly notes, the multiple meanings of human rights as an ethical project and as legal regime pose a limit to what is actually practically achievable by employing the human rights discourse (Kelly 2012). The legal and individualistic nature of the human rights project limits its ability as a resource for overcoming the injustices of the social systems and political regimes that often remain beyond its reach. Similar observation is expressed by Samuel Moyn in his book *The Last Utopia* (Moyn 2012). Moyn traces the history of the concept of human rights as it has been employed in the latter half of the twentieth century and analyses various social and political movements inspired by it. He examines specific contexts in which this concept has flourished over the past decades – including the Charter 77 movement – and compares the strategies adopted by various social and political movements. Moyn concludes that the project itself is yet another variation of utopian dream that yields itself to inevitable inner contradictions and ultimately becomes the instrument of politics:

“Born in the assertion of the ‘power of the powerless’, human rights inevitably became bound up with the power of the powerful. If ‘human rights’ stand for an exploding variety of rival political schemes, however, they still trade on the moral transcendence of politics that their original breakthrough involved.” (p. 227).

The context of Czechoslovakia therefore represents a case study to his claim: the transformation of this concept from the dissent movement in the 1970s to the integration within European institutions in the late 1990s represents a shift of emphasis from that of social solidarity to much more individualistic claims to particular political, social and welfare rights. However, this shift fails to do justice to the richness of the original conception and its promises. Social solidarity easily disintegrates into conflicting interests and rights of individuals. If there is none to act on the behalf of those who are unable to claim their rights, these rights remain silent.

## Concluding remarks – Part I

### What We Missed: The Ethical Grounding of Politics

How can we understand this process of attempted reform of psychiatry and mental health care after the fall of socialism? How can we retrospectively assess the not only the outcomes, but also the intentions and strategies of individual actors, organisations and institutions aiming to improve conditions for the mentally ill? What is the significance of what did not happen although it was being hoped and aimed for?

In his study devoted to the understanding of historical time, German historian Reinhart Koselleck introduces two concepts that convey and constitute the experience of historical reality: the space of experience and the horizon of expectations (Koselleck 1985). Drawing on the assumption that time can only be expressed in spatial metaphors, the metaphors of ‘space’ and ‘horizon’ offer appropriate categories for the experience of historical time. Experience is present past, the events incorporated into the landscape of memory; expectation is the future made present, taking the present to the not-yet, to that which is to be revealed. Experience is related to the modality of memory, expectation to the modality of hope: *“It is the tension between experience and expectation which, in ever-changing patterns, brings about new resolutions and through this generates historical time.”* Koselleck is especially interested in the historical time of rupture, where the open horizons suddenly also change the landscape of the present, as new possibilities are opened up. It allows one to see a future that is imagined although not always eventually realized. Even this imagined future exerts a powerful influence on how the present is experienced – and how the past is reinterpreted.

Koselleck’s ideas thus offer a nuanced approach to situations of historical discontinuity. The legacy of the past – recent as well as more ancient – is layered in many aspects of social life, cultural patterns, and human interactions. The associations of various social phenomena and cultural practices and their

explanations and justification in terms of various theories and ideologies do not represent the only inevitable configuration: they could easily be – and in other contexts are – tied together to create entirely different realities. Historical progression is therefore more like a mosaic where individual elements are connected to create an inhabited cultural world and these connections are subject to reinterpretations, revisions, and alterations. The occasion of sociopolitical change often offers the opportunity to rearrange the individual fragments into a different narrative. The phenomena and processes attributed to the communist regime often have much deeper roots, but their association with patterns of the recent past were used to create the distance and emphasize the discontinuity of time. Despite the discontinuity in the political sphere there are nevertheless always continuities in cultural practices – although these tend to be reinterpreted in a new light. The historical rupture opens up a new horizon of possibilities and these hopes and possibilities are a significant part of historical reality as they shape the course of events even if not all of them eventually materialize.

In pre-1989 Czechoslovakia the hopes of the Charter 77 movement were for a society that is respectful to the individual and organized in accordance with the demands of justice. The events of the 1989 revolution made these hopes seem attainable. In times of historical discontinuity the utopian visions of society that would be inclusive and sensitive to the needs of its members often guide the revolution and legitimize the demands for a new social order. The political discourse of early 1990' was instilled with ethical language as evident from Havel's speeches, and the social and political transformation was then perceived primarily as an ethical project where the human solidarity should find its expression in the institutions of civil society. Ladislav Hejdínek, one of the signatories and later spokesman of the Charter 77, writes:

“The essence of freedom is to aim for justice, and above all justice for those who are denied their rights, for the weak, humiliated, overlooked or even discriminated and persecuted. This is the essential content of any non-political politics, to fight for a greater space for humanity. That is why we fight for civil and human rights. Political indifference and ignorance only helps the illegitimate intrusion of the state into human life; true politics, on the contrary, true civic engagement finds its expression

in the private sphere, on which state politics and institutions have no right to intrude. What is decisive is the solidarity of human beings with one another; state politics at its best can only be its consequence.” (Hejdánek 1993)

The belief that politics always has to be grounded in ethics was one of the main motives of Charter 77 and similar social movements in the late socialism. With the political change of 1989 the hope was that the new social and political order will be derived from the ethical demand and that personal freedom will be interpreted as a responsibility for others. The redemption from the totalitarian regime was expected in form that this human solidarity will penetrate all social life and political institutions, and result in kinder and more generous treatment of the vulnerable and disadvantaged members of society. The communist regime was actively preventing the social initiatives of citizens and so the independent social, cultural and religious initiatives were taking place in the ‘unofficial’ sphere – what some referred to as *parallel polis*. The Charter 77, one example of such an initiative, is commonly understood as a critique of political disrespect to human rights and liberties and as a challenge to the repressive regime. However, especially throughout the 1980s, their critique became primarily a social critique – a critique of indifference to human hardship and misery. In some cases this is caused by the oppressive political regime but extends well beyond that. This is the perspective expressed in writings of Ladislav Hejdánek, on what he considers to be the true essence of democracy:

“Socialism emerged as an extension of democratic principles to the social and economic areas. History has shown that the democratic principles are rather in vain if they are limited to the sphere of politics. Modern democracy disappoints many because it never realizes its own principles. What good is it to declare that everyone is born free and equal in dignity and rights, if a newborn baby appears in a family of hardship without any support? Socialism in the true sense refers to a society in which a person relates to others as their friends and neighbours. That is not primarily a question of social organisation but a question of the actual relationship of one person to another person. I must be a friend to people who endure hardships, the weak which are ill treated, those who suffer, those who are disadvantaged and discriminated against, those who are ill, old, or pushed to the margins of society; in other words I need to become friend and neighbour to them. We have plenty of such opportunities around us every day. It is only about whether we care enough for others to make our lives a bit more complicated. This is the most practical thing in life and the easiest way to the society that allows for genuine human life. And you do not

need to much for that: just open our eyes and see the real human misery and do everything that is in our power against that. (Hejdánek 1993 p. 29-30)

This is also an attempt to rescue the notion of socialism by appealing on everyone to take seriously their responsibility towards others. This interpretation of human rights as responsibilities towards others has had a long tradition in the Czech intellectual context (Trojan 2002). Shared condition of vulnerability and insecurity grounds the responsibility of one person towards another, in what has been referred to as existential grounding of politics. These motives that were elaborated by phenomenological and existential philosophy thus had wider resonance with the experience of threat and menace under totalitarian regime and have influenced the understanding of politics. The experiences of being shaken in the taken-for-granted certainties of life or encountering someone else's suffering become the foundation for political action not in the traditional sense of the exercise of power or the struggle for concrete, specific things. Czech sociologist Miloš Havelka interprets the notion of apolitical politics in the wider context of the philosophy of existence:

The conception of 'anti-political politics' has yet another, more universal and more radical meaning. 'Antipolitical politics' came into play also as a very specific critique of culture and civilization and was interpreted as a beginning – as well as the first means – of the 'existential revolution'. As an 'existential revolution' non political politics represents a perspective on the moral reconstitution of the society and a means to unveil the mask of the fallenness." (Havelka 1998)

Under the totalitarian regime where the transformation of the political regime is impossible, the non-political initiatives of citizens then inevitably become political. This is what is understood by the notion of 'apolitical politics'. In the October 1989 interview for the samizdat journal, Havel presented this perspective very poignantly:

"For forty years we have witnessed the destruction of politics as a specific form of human activity, slowly transforming into a boring phrase that we cannot easily get rid of. However we are also coming to the realization that the political means also a rock concert, a mass, or art exhibition. Everything becomes somehow political, cryptopolitical, everything gained a waft of the political. And if a writer spends his whole life writing what he is convinced of and says the truth the way he sees it – with no regard whether the governments likes it or not – that of course becomes the political phenomenon 'par excellence'."

The last two decades can be understood as an aftermath of socialism, coming to terms with the legacy of the past and a striving for a better future and a different society. The fall of socialism opened new horizons of possibilities and altered the space of experience by granting the freedom to individual actors to bring about desired change. It allowed for new and more immediate forms of social solidarity to arise from the background of state-governed provision for its citizens. However, the various areas of social life have not evolved synchronically: the economical transformation of the nation was the priority, while the sphere of health and social care, for example, have shown much slower progression of transformation or reform. While many studies of post-socialism have focused on the realm of the political and the economic where the transformation has been more rapid, my interest has been in examining the areas of social life, structures and institutions, which were ‘left behind’ in this process. The area of social and health care – the care of the chronically mentally ill especially – seemed to be on the periphery of social and political concern and in the years following 1989 was actually marginalized and deprived of resources which were steered towards the economical transformation.

There were several initiatives in psychiatry which saw the change of the regime as an opportunity to completely change the way care for those with severe mental illness was provided and which were taken forward in several different directions as the project of ‘humanization of psychiatry’. I traced these initiatives from their origins in the unofficial, underground culture before 1989 in the context of apolitical politics inspired by Charter 77 through the period of early 1990’ when various initiatives gained momentum and established themselves in the public arena. I also examined the life of the initiatives in the more recent period where joining the European Union became a significant cause for the transformation. This time was nevertheless also characterized by gradual stagnation and the exhaustion of enthusiasm that was driving the attempts for change.

It is interesting that most of these initiatives to improve the situation were organized by the psychiatrists themselves who decided to act on behalf of their patients. It was not the state who would initiate and organize comprehensive reform,



and neither were there many representatives of state institutions such as policy and law makers and that would insist on the reform. The psychiatrists understood the task to improve conditions of psychiatric care as their civil – and even political – rather than just a professional responsibility. This is a confirmation of Koselleck's emphasis on the importance of individual agents for historical change: *"There is no history which could be constituted independently of the experiences and expectations of active human agents."* (p. 269; 275). Koselleck's argues that the future does not simply come but is shaped by the expectations and deliberate action of individual actors. In this case it was the initiative of individuals that enabled or facilitated the desire for change. The new political reality seemed to make the ideals of Charter 77 movement materialize and thereby transform the society (Tucker 2000).

Despite being well intentioned to emphasize the urgency for change, the initial symbolic association of large hospitals with totalitarian power has had rather unfortunate consequences for the professional community. This further weakened its abilities to exercise pressure on political structures and insist on the implementation of their proposal for transformation. Moreover, the inability to negotiate the responsibilities of the psychiatric profession, civil society and the state in the new political context proved detrimental for the mobilization of the resources that were necessary to achieve their goals. The impediments for this endeavour that were originally attributed to the communist regime thus persisted in different forms in the post-socialist time since sociopolitical change also created new power structures and different priorities and these paradoxically became obstacles to fulfilling the ideals that gave the rise to them (this is also true for the political representation as in Eyal 2003). Additionally, the criticism from the international community in the area of human rights proved to be inefficient and even counterproductive in a situation where the formerly centralized state power was weakened by recent political and economical changes. As time went by the impulses for social change that resulted in initiatives described in this part of my thesis gradually lost their momentum when permanently confronted with the indifference and incompetence of the state power structures and economic forces. Although in democratic societies the initiatives and

responsibilities rest with individuals, the state as the expression of a social contract must still play a role to provide resources for attaining the common good and acting in interest of its disadvantaged citizens.

It is often thought that the concept of civil and open society – which has been extremely influential in the political discourse of early 1990' when writings of Hannah Arendt and Karl Popper became available to wider readership – is an heir to the concept of apolitical politics. Nevertheless, Miloš Havelka argues for the asymmetry of these concepts: the expansion of anti-political politics is related to the absence of civil society, whereas the existence of civil society does not necessarily require anti-political politics because the need to build a 'parallel culture' does not arise there. The historical and political conditions have changed in the very demands they make on individuals:

“After the November revolution the concept of apolitical politics has been relatively quickly abandoned in a confrontation with reality that could not have been embraced by a particular intellectual gesture. It soon became apparent that for modern democracy the reconstruction of economics and privatization were primary. The idea of an authentic personal life represents an important but by far not sufficient condition, because our situation is not as metaphysical as it is pragmatic. Of course this should not lead to the defamation of attempts to remember civic virtues, public and national interests or the values of nature and culture.” (Havelka 1998)

This pragmatic reorientation of the post-1989 politics which took over the ethical hopes and ideals that gave rise to the transformation resonates also with the motive I was hearing over and over again in interviews with my informant – the notion of missed opportunity. Perhaps there are times when social and institutional changes are more likely to happen – when the old ways are questioned and new solutions sought with the rupture of time, when the disintegration of the system allows the pieces to be put together in a different way, or when power on behalf of the powerless is not yet appropriated to serve other purposes. But such moments can also be discarded and dissolved within various other political projects. Many informants expressed the sentiment that it might well have been that the momentum of post-revolutionary enthusiasm was THE opportunity that nevertheless proved as a vain hope – as all utopias are. In the words of Lucie Rybová:

“If I look back to the issues we brought to attention for the past several years, it is the same issues repeating all over again. It means we do not have to look for new and new issues but it would be enough to apply sufficient pressure on the consistent application of these principles. I think we missed the right time after 1989 where there was a chance to bring about the change – well there were all these attempts and it was a good start – but it never got us anywhere, really. Although, there are some little changes at least – for example, patients now are allowed to have a walk in the park...”<sup>129</sup>



Leaves growing through the broken windows, Bohnice hospital, 2007

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<sup>129</sup> Lucie Rybová, interview January 2008

## **PART II**

### **THE LANDSCAPES OF MENTAL ILLNESS**

## Introduction

### Medicine as Knowledge and Care



The church and former monastery building, Kosmonosy hospital, 2007

When one enters the space of psychiatric hospitals what one encounters is not just the present: there is also the past which is present in the material culture, in the practices of care, in the intellectual tradition of medical knowledge and the ways these are applied in treatment. These layers of cultural heritage create the background on which the interactions in the hospitals occur and from which the current practices derive their meaning.

Throughout my time in the psychiatric hospitals listening to the various conversations and observing the encounters of patients and staff I was often reminded of a stone carving from a medieval Chapel portraying the religious concept

of the *Seven Corporal Works of Mercy*. In his *Summa Theologiae* Thomas Aquinas describes mercy as “*the compassion in our hearts for another person's misery, a compassion which drives us to do what we can to help him.*”<sup>130</sup> Although mercy is related to the virtue of charity as a spontaneous act of sympathy towards others, mercy is also an act of justice, the impulse to redress the harm and relieve them of their misery. Among the corporal works of mercy were to feed the hungry, to give drink to the thirsty, to clothe the naked, to harbour the harbourless, to visit the sick, to ransom the captive, and to bury the dead. These acts address the physical and material needs of the other person and they are complemented by seven spiritual acts of mercy that attend to their soul.<sup>131</sup>

The medieval distinction between the corporeal or material and the spiritual proved to exert significant influence in European culture. In the centuries that followed and especially with the rise of science – itself originally considered a form of spiritual exercise and a way to repair and heal a fallen and fractured world (Harrison 2007) – medicine was one of the institutions to provide care and possibly also a cure the ailments of the body while religion was left to take care of the soul. In an interesting formulation from the Fourth Lateran Council of 1215, these realms are regulated respectively: “*Physicians of the body called to the bedside of the sick shall before all advise them to call for the physician of souls, so that, spiritual health being restored, bodily health will follow*” (Canon 22; 1215). The religious and the medical have nevertheless intertwined both in the ideas about the origins and nature of illness and in the provision of care and treatment for the affected. Psychiatry represents a rather complicated case of the interactions between religion and medicine: although mental illness was for a long time considered an affection of the soul or spirit – in the Czech language the notion of mental illness translates literally as the affection of the soul – in the course of the last two centuries medical science claimed this territory. Psychiatry now offers material explanations for inner life in terms of neurobiological

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<sup>130</sup> Thomas Aquinas. *Summa Theologiae* II–II.30.1

<sup>131</sup> The seven spiritual acts of mercy that attend to the soul of the other person are: to instruct the ignorant, to counsel the doubtful, to admonish sinners, to bear wrongs patiently, to forgive offenses willingly, to comfort the afflicted, to pray for the living and the dead.

processes in the brain – thus emptying or rather annihilating the concept of the soul (Zimmer 2004; Porter 2004). This shift does have implication for interpretation of the role of psychiatry in contemporary society.

In his book *Mending Bodies, Saving Souls*, Günther B. Risse describes the history of hospitals in Europe (Risse 1999). In describing the origins of these institutions he notes that for most of European history hospitals were places of mercy, refuge and also death. These were mostly monastic shelters and infirmaries and it was the church which mediated between life and death. The last sacraments were administered to believers expecting salvation who surrounded by prayerful caregivers waited for their redemption: the church mediated between the life and death. However, the hospitals also served as places of segregation and confinement especially in the era of leprosy and plague epidemics. Hospitals were often designed as secluded complexes away from cities and towns. It was only in the eighteenth century with the rise of the profession of medicine that the emphasis moved toward systematic clinical observation, treatment and experimentation with drugs.

It can be said that the psychiatric hospitals in this region bear the traces of all of these different modes of care including refuge, seclusion, and medicalization. The noble ambition of medical science to understand the origins and physical causes of maladies, to intervene in the pathological processes and invent cures for diseases has significantly transformed the landscape of human suffering in medicine as well as in psychiatry. Although the dialectics of knowledge and care have taken different forms throughout history, medicine's endeavour – assisted by science – has been to add the virtue of 'cure' to the traditional list of the works of mercy.





The entrance to the hospital through the administrative building, Bohnice hospital, 2010

Recent centuries have also witnessed a slow transformation of the ethical impulse to address the material needs of others into different forms of social institutions: first ecclesiastical, later secular, and most recently in the form of a welfare state. In Central Europe from the eighteenth century onwards medicine became an indispensable assistant of the state to provide for the needs of their population: the ‘Königlich-Böhmische Landes-Anstalt für Geisteskranke Bohnitz bei Prag’ – the Bohnice hospital – was devoted to the mentally ill by administration of the Viennese emperor in 1909. The design of the hospitals still embody the belief that the environment – the design and architecture of the physical place – should have therapeutic effect on the patients seeking treatment and healing.



## Chapter 4

### The Spaces of Mental Illness

#### Kosmonosy Hospital



Kosmonosy, photograph from 1918, the hospital viewed from the village (archive)

*Uncollected garments shall be retained for one month after discharge, escape or death.*

Notice on the doors of A 14 ward, Kosmonosy Hospital, 2007

*“If the angels from the altars in the church of the Piarist monastery woke up alive and took you on their wings, brought you up to the highest altar, and opened the forgotten little doors there, you would enter into a room where Mirek and others rested at night. The fact that the Piarist college became a bad shelter and a prison bunker did not prevent Mirek from becoming a good student. The nature around, the trees in the park all became a clearly legible book of Wisdom.*

*We parted for some time.*

*In the moment he was leaving, the altar angels from the Piarist church woke up. They opened the little door which Mirek already suspected to be there. It was his turn to*

*leave behind the battles and pain and be taken away on the wings of the angels. Hardly any water from the ocean of pain of this prison bunker called a psychiatric hospital vanished. Only someone whose presence gave meaning to the pain, and whose hands reached through the bars to open the window when the sun was rising over the horizon, departed, quietly.”*

Mirek Pátek, In Memoriam. P.S. 1991<sup>132</sup>

Kosmonosy is a small village situated on the southern side of hill overlooking the valley of the Jizera river that comes down from the mountains to join the Elbe in the lowlands north of Prague. Flourishing in Baroque times Kosmonosy village was in 1670 granted a beautiful church – the Elevation of the Holy Cross with its adjacent Piarist monastery built by Italian architects Francesco Carrati and Giovanni Maderna in 1692. The nearby Loreto – Holy Shrine – by Giovanni Alliprandi is considered the most beautiful Loreto north of the Alps. In the late Baroque the pilgrimage to the shrine was a common way of seeking redemption from bodily and spiritual troubles (Lederer 2006, Tinková 2005). The shrine attracted pilgrims from the whole region of North Bohemia and beyond from Saxony who came here to seek blessing, healing and reconciliation. If the angels in the Church remember, they might recount stories of those who came: prayers of hope, human misery, pain and faith, in different languages and idioms.

In 1867 the Bohemian Royal Provincial Commission decided to buy the monastery premises and convert them in hospital for the insane as a solution to the growing demand of treatment of people with mental derangement. This was done on the advice of Dr. Köstel, the first professor of Psychiatry at the Prague University and director of what at that time was the only mental hospital in the Bohemian Provinces. Two years later the Royal Bohemian Provincial Asylum for Insane was officially opened in Kosmonosy and welcomed its first 282 inhabitants – all of them male patients coming from Prague. Not long after that additional buildings in neighbourhood close by were purchased by the asylum and the female patients found

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<sup>132</sup> Mirek Pátek, In Memoriam. P. S. in Mosty No 6., 1991/1 It is the same patient Dr. Martin Jarolímek was remembering in his account of Kosmonosy.

their home here as well. All of these patients were considered incurable. In addition to mental illness patients also suffered from additional physical conditions and thus required constant custodial care. Soon after, another two large buildings – each for three hundred patients – were built as a part of the hospital, with the overall capacity reaching to more than one thousand beds. In addition to the accommodation facilities and a large administrative building, the whole complex consisted of gardens, orchards, a farm, laundry, and various workshops where those patients who were still capable of working did so.

It was not unusual at that time that formerly sacred spaces were used for secular purposes. However, the particular spatial layout nevertheless posed difficulties since the chapel and the former monastery – now used as a hospital – formed a single unit. A solution was embarked upon: the ground floor of the sacristy of the chapel was retained by the church while the first floor was given to the hospital, and the two towers of the chapel were also split between them – one of them is repaired now by the Catholic church, the other one still in decay after decades of neglect by the state. However, there is still something unusual about this fusion of sacral and secular space in an institution that is a long term hospital. The walls of this hospitals have withstood the times, bearing a witness to the lives and deaths of the patients for over a century. The patients do not come as pilgrims anymore but still come here with hopes for healing that might not be that dissimilar to those of pilgrims in the past. I have heard references to purgatory and hell from both patients and doctors working in the hospital which still has the reputation of a place with no return. As the notice on the door states rather crudely, there are three ways out: discharge, escape, and death.

Today the hospital has 650 beds for acute and especially long-term care with specialized wards for patients with mental retardation, sexual deviance, addiction, criminal history, and geriatric wards. In many cases medicine has very limited repertoire of what it can offer to the patients: the hospital provides nursing care and observation, medication that at least in some cases alleviates the symptoms of the illness, calms down anxieties and provides some comfort, but rarely does it provide a

cure. Patients slowly disappear in their illness – illness that transforms them into remnants of what they used to be. In the hallway of the shrine the wooden angels from the chapel were laying on the floor waiting to be repaired and they seemed to me not dissimilar from the patients coming to the hospital waiting for healing and redemption.



Angels in the hallway of the shrine, Kosmonosy 2007

## Coffee and Cigarettes

The medical doctor whom I followed most closely during my time there was Dr. Iva Tlášková, a very kind and generous woman in her late forties. She was responsible for three wards – the female admission ward, the female chronic care ward, and the intensive care ward. All of these were located in the only building of the hospital that has undergone complete reconstruction recently and therefore unlike many other wards did have the feel of a hospital – rather than a derelict ancient nursing home. On the first day of my internship when I arrived in the hospital I encountered her half way through her ward round on the admission ward. Accompanied by three young female doctors, three psychologists, social worker and four nurses she enters each room, greets the patients and asks them how they are, makes decisions about medication and whether the patient is allowed to have a walk in the afternoon. I was warmly welcomed by the staff, although with a bit of surprise why I voluntarily came to this place. After the ward round finished I was invited to join the doctor on the intensive care ward round. Unlike in other wards where the room hosts five to fifteen patients, these rooms are just for two or three patients each. However, only two nurses are there to take care of these patients that demand a lot of attention since most of them are immobile and have severe physical health issues in addition to their psychiatric conditions. The nurses were complaining to the doctor about the problem with laundry – the washing machine was broken and the whole hospital had to rely on the few clean pieces left. One of them was commenting bitterly that the time had come when they have to ask the relatives to provide not only the diapers but also sheets and bedlinen that the hospital cannot afford to provide.

The only mobile patient on this ward comes to greet the doctor and with a smile offers her a chocolate bar while asking her to discharge him. Admitted for a metabolic crisis associated with acute alcohol intoxication, he promises not to drink anymore. The doctor does not want to accept this gift and says she will be back in the afternoon to talk to him. The patient thus gives the chocolate to the nurse instead and

she places it on the table next to the leather restraints and a metal screw. Looking at the screw, the nurse informs the doctor that another patient told her she had eaten a screw from her bed. Upon closer examination, the patient denies it for a while only to confirm it again few minutes later. The nurse ask the doctor what should they do – trust her or not? The patient is well known to all the staff there – her medical documentation weights at least ten kilograms, as the nurse carrying her papers complains. About a year ago she burned herself in a suicide attempt and, after being hospitalised in specialist clinic in Prague for six months where she underwent multiple operations, she was ‘returned’ to Kosmonosy. That was her fifth suicide attempt. The doctor comes and talks to this middle aged woman who is lying in her bed on a corridor so that the nurses can keep an eye on her. Despite being reassured by the patient that she has not eaten the screw the doctor wants to make sure and sends her for X-rays to a nearby general hospital. Her suspicion was confirmed: the screw was indeed found in her stomach. This hospital nevertheless refused to admit her in their hospital after the short surgical procedure since she is a ‘psycho’ as they explained to the psychiatrist. They recommended that the patient be returned to the psychiatric hospital and is given a lot of cabbage to eat: this should prevent the potential rupture of the intestines. The whole episode is concluded three days later by having the screws reinstalled in her bed. In the meantime, though, the patient has to be restrained as a prevention of any potential mishap and her bed placed in the corridor so that she could be observed constantly. What else can they do when there is only two of us for ten patients needing constant attention – asks the nurse, helplessly, while washing an unresponsive patient, moving his inert body and providing his bed with clean sheets.

We continue our way through the rooms. Most of the patients are elderly and some are not able to communicate anymore due to progressive dementia. The doctor comes close to them, touches them gently, and asks how they are. After hearing the response from the nurse she proceeds to the next patient. The medication and nutrition given to these patients is discussed so that the expenses fit within the narrow limits of finances that they can use for this purpose: the patient can be given



either nutridrink or food (not both, as the hospital budget does not allow for that), and the financial limit for medication is 45 Kč per patient per day.<sup>133</sup> The staff is able to comply with this policy only thanks to the pharmaceutical companies who provide some two thirds of necessary medication as ‘free samples’ – this generosity being explained by the small proportion of patients who are discharged and continue on their medication for years, as one of the doctors told me.



Administrative building, Kosmonosy hospital, 2007

Half way through the ward round the doctor is called by another ward and requested to come to see their ‘three roses’. We leave, climbing up the stairs to the top floor where female chronic ward is located. Most of the patients here are suffering from mental retardation complicated by additional psychiatric conditions. The doctor opens the locked door to the ward and without any warning one of the patients jumps at me from the back, screaming and showing me her infection

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<sup>133</sup> about 1.50 GBP

spreading all over her body. The nurses ask her to stop it – relieving my shock and intense feeling of repulsion – which I am ashamed to feel but I feel nevertheless. We pass two women lying in the corridor on their plastic bags – a dearly held treasure obtained from a nearby supermarket as the nurses explain to me. The patients remind me of the homeless people I see every day on my way to the train station in Prague, but at least these have warm place to stay. The rooms are empty of people but they are rather crowded with old metal beds, some of them net beds – security beds. Finally, we enter the room of ‘three roses’: three patients – two of them entirely naked and the remaining one covered from toe to head with her sheet. The nurse explains me that it does not make any sense to try to dress them up. They destroy it within few minutes since this is what they prefer – and why not, actually, she adds with a gesture of resignation. Two of them do not seem to be present at all as if their bodies did not belong them or, rather as if they did not belong to their bodies – the only certain sign of their presence in the world. Yes, it is erysipelas. They need to get the antibiotics, and all other patients need to be checked for potential signs of infection. Not a rare occurrence at these wards.

We go to the office and write it all down, have a discussion about the appropriate dose of antibiotics for one of the women weighting 160 kg. The nurses are rather patient, smiling and kindly answering the questions of patients and explaining to me a lot about their individual stories. Most of the patients stay here for years. Most of them do not get any visitors. Most of them will never get out from here. They tried to transfer some of them to social care institutions where the conditions might be better for them, but did not succeed: the institutions did not want to take them as they are psychiatry patients, and the families – where there were families – did not want them either. As one of the nurses adds with a fair amount of cynicism: the families would have to contribute financially to their care in social care institutions, while the hospital care is for free.

Three patients come to speak with the doctor and request to be discharged. All of them are dependent on alcohol and drugs. They promise the doctor not to touch a drink or anything only if they are discharged – but who could even think of



trusting them, says the nurse? Indeed, most of the patients here are alcoholics suffering from delirium, drug addicts with severe cognitive impairment and patients with chronic schizophrenia. One of the nurses comments bitterly that you hardly meet a genuinely insane on this ward: these are just human wretches.

Discussing the medication of another patient the doctor tells the nurses how she met her the other day in the garden begging for money. She gave her fourty crowns. As the patient realized she would indeed get something from this doctor, she increased her request for fifty. We all laughed. The laugh somehow helps to lighten the reality. Another patient brings some pictures she drew as a present for the doctor. The doctor has gotten pictures from her regularly for the last twenty-something years. The daughter of this patient is now hospitalised in the ward downstairs – Aneta.



Acute care ward for female patients, Kosmonosy hospital, 2007

The next day I join another doctor who is responsible for the male geriatric ward. She is a young doctor and she openly shares her doubts about this hospital with me. She used to work on this ward but somehow could not get along with the doctor in charge. However, this doctor was recently brought to another psychiatric hospital for alcohol abuse and she was called upon to take his place. This young doctor criticized him for not caring about anything and as a testimony showed me his inscriptions in the patient documentation: stamps, stamps, stamps. No individual comments to report on the patients. But actually, what can you write here when nothing really changes for weeks and months for the patients here? Only very few of the patients will ever be discharged home or transferred elsewhere. The rest of them will die here. After his return from treatment the senior doctor told me: “That is how you end up being compassionate. It is a purgatory here.”

There are five deaths in a month on average in this ward, the last one just last night. The nurses on the night shift already filled in all the forms. The name of the patient was deleted from the computer system. They informed the family and reported to the doctor that the patient’s daughter expressed her thanks.

“What time did he die?” asks the doctor.

“Well, I do not know. The dead are not in a hurry to get anywhere, you know. When I came at 5am for the morning shift he had been written down already, so it must have been before that, but what time I do not know. This old man actually told us on Friday that he will die, and indeed, that is what he did.”

Sometimes it is difficult to talk to the family, especially when the death is not expected. Sometimes it is more like announcing what they hoped for. Sometimes they do not show any concern for the deceased, the young doctor explains to me. The patients just flatten and die. Sometimes the nurses tried to guess who will be the next ‘death’.

We go back to the staff room where all the other nurses sit, smoking and drinking their coffees. The doctor invites them to join her in a ward round. They smile at her and ask whether that is necessary to have a ward round as nothing really

happened since yesterday apart from that one death and the fact that the senior doctor did not turn up today.

I am invited to join another doctor on the ward round through the male chronic ward. This ward does not really look like most hospitals I have seen during my medical training. It is dark with broken furniture, broken floor, beds with restraints, the smell of urine, purulence and dirt, 7-10 beds in one room – otherwise empty. The patients are dressed up in rather funny clothes that are full of holes. Each sock different if they have any at all. We pass through the corridor where some patients sit on the benches, silent. One of them is having his leg bandaged.

“What happened?” asks the doctor? “Nothing, nothing”, he says. “Hello, hello, hello, hello... it is nice you came”. “Let me see your hands, how is it with the infection? Well, it is almost gone now, well done!” I look at the patient’s hands the doctor holds in hers: the infection is gone but two fingers are missing. We move on to greet another man.

“Hello, Mr. X, how are you?” “Fine...” “And what about your mood?” “Fine.” “What is the day today, do you know?” “Not know..” “And what year?” “Not know.” The same question is repeated ten times, but actually, there is really no time here. It is a timeless place.

“How are you?” “Well, well...” “What about your mood?” “Well, well...” “And what about the cigarettes, anyone steal them from you?” “Not today, I have them with me all the time, you see”.

We continue to the smoking room. It is again very quiet here, everyone is silent but you can hardly see them through the smoke. “Hello, hello, everything all right here?” “Yes, yes...” “Have a nice day, then” “Yes, yes...”, the man smiles at the doctor with open mouth and no teeth. At least these patients are not homeless, although they often look like that.

Next comes the ‘intensive care’ room, full of net beds and beds with restraints. One man is restrained by ropes attached to the bed. Others are sitting or lying inside the net beds, looking nowhere in particular. “Hello, how are you today?” No reply. She touches his hand: “Well, Mr. Pavelka, how are you today?” No reply.

“He ate a bit, better than yesterday” – the nurse replies on his behalf. “Well, we now leave him naked, he ripped his clothes and the sheet into pieces twice yesterday. We restrained him, he stayed for three hours like that, and after freeing him he did the same thing again, so we just gave up”.

“Good morning, Mr. Hvozdk, how are you?” He shakes his head gently in reply. “Well, do you know what day is today?” No. What year? No. What is your name? No. Have a nice day, then.

“Good morning, Mr. Zubr, how are you?” “How dare you ask me that???” he shouts. “Well – I only wanted to know how you are?” the doctor replies gently. “How can you ask me such a thing? You see, I would just run away from here and jump under the train if only you let me out of here, but you treat me like in a prison, so how you dare to ask how I am?” “Well, and what about your anxiety and your restlessness?” “We had to give him an injection yesterday”, replies the nurse. “And the barber should come soon, look at him. But he already owes the barber 320 Kč so I am afraid he would not shave him anyway.”



Chronic ward for male patients, Kosmonosy hospital, 2007

We return back to the corridor where the doctor write notes into the patients' documentation. 'Smiling', 'Non-responsive', 'Better, wants to go out in the afternoon', 'Restless, anxious', 'Sitting in the chair, crawling, one-word responses, poor expression, significant cognitive deficit'. That's it.

Another ward calls whether they could transfer someone as they saw the one vacated place in the computer system. "We have two men here, you can come to see them if you wish and choose. They are on diapers but not aggressive". "Well, Ok", says the nurse, "if we must take them we will. Never mind if they need diapers, we can deal with that, but only if they are not aggressive so that we could lock them in the cage if the need arise." There is not a single male nurse in this ward although the work is really demanding and requires lifting and moving inert bodies of these patients, and calming them when they get agitated and anxious. The only three male nurses in the hospitals are in the forensic ward to take care of patients with severe criminal records.

As the two patients arrive one of the nurses welcomes them nicely, offers them slippers with holes – each of a different size but unfortunately there are no others to offer – and new trousers as the old ones do not fit at all. She takes them to their beds. She is very kind, helps them to dress up, touches them gently. The doctor later tells me that this nurse is rather exceptional, always kind and patient with these miserable people. One of the patients offers a smile in return – although a bit absent smile. The other responds angrily. I cannot understand what he says but it is definitely not 'thank you'. Both of them are here with organic trauma syndrome after many years of alcohol abuse history.

It is time for lunch. The staff dining room is the most recent addition to the complex. It is behind the monastery walls and with a view to the horse field. It is spacious and light, decorated by large paintings by the patients. I am introduced to the other doctors who invite us to their ward for coffee and chocolate which they received from one of the patients. After that I go back to the admission ward and follow the doctor to the intensive care unit where they just received the results from microbiology. One of the patients had three different antibiotics already but the

infection does not seem to be over and now, it is MRSA. What shall we do? There are ten beds, all full, so there is no way to isolate him, and, what is worse, his fellow patient who shared the room with him for two month has recently been transferred to another ward. He must have gotten it as well, since he would often lie on the floor and once he was found drinking the urine from the bottle of this other patient. The whole ward now probably has it, as well as the staff. But there is no way to deal with that. The nurses call to the pharmacy for a special disinfectant, but are told they have to wait for another week since they have to order it. Should we tell the other ward about the infection or rather not, asks the nurse?

Most of the patients are brought to the hospital by their families, by ambulances, or by the police. After some time on the admission ward they are transferred to specialised wards located in different buildings. Most doors have multiple locks on them and most windows have bars. Only few wards have an open door policy which allows patient to come and leave any time they want to. Most wards are either male or female, hosting patients with similar conditions, and also triaged for their usual behaviour – ranging from ‘calm’ to the ‘agitated’. The progression from one ward to another is therefore based on a judgment about the medical condition and behaviour of the patient. Among the patients there is often a distinct hierarchy of the wards. There are some they like and others they would want to avoid at any cost. The staff also contributes significantly to the overall atmosphere and regime of the ward and this is taken into consideration by patients when making their judgments about different wards.





Hall with a dining space on a ward for male patients, Kosmonosy hospital, 2007

These are patients who have no families, no significant human relationships in the outside world. Their ties with the world behind the walls of the hospital slowly disintegrate. Some patients do not seem to notice as their illness has made them indifferent and they have slowly forgotten the meaning of the word 'home'. However, I have also witnessed patients crying that they have nowhere to go, and that nobody wants them. Some patients actually prefer to be in the hospital since in the outside world they encounter only ridicule, mockery and ill treatment. There are patients who call the hospital 'home'.

Hospitals are currently one of the few places where people share room with complete strangers. The pattern of patients coming and leaving gives these wards an unusual feel of fluidity. This requires significant adjustment in terms of privacy: some patients do not mind and welcome the opportunity to share their everyday life with others, while some other patients tend to withdraw from their surroundings and appear to be absent. Some patients after months or years of life in the hospital refer

to their room as home. Some other never adjust to this permanent intrusion of their privacy but they generally do not have any choice than to be resigned to it. In some cases their roommates can be difficult or disruptive and there were always several patients in the ward with whom nobody wanted to share a bedroom either because of their smell, their unpleasant or aggressive behaviour, or their snoring and screaming at nights. There are also times when there are not enough beds and newly admitted patients have to be accommodated on mattresses either in the rooms or in hallways.

In some wards the bedrooms are locked during the day so even the bed – the only place the patients can claim as a private personal space – is not available to them. They spent their time in the corridors, or in the smoking and dining rooms. The reason for locking the bedrooms is that there is not enough staff to ensure the security of all the patients and the hallway or common room is a more easily controlled space. Usually there is a room on the ward divided by glass from the nurses room which is devoted to patients who for different reasons are bed-bound. This arrangement allows for their observation.

Medication is distributed three times a day by nurses. Patients are waiting in a row in front of the nurses room, with their hands open – strongly reminding me of the way in which the Eucharist is distributed in the Catholic church – not entirely out of place in this former monastery. Very often the doctors complained that they are overwhelmed by people to whom they have nothing to offer, for whom there is no hope really. However disfigured the patients are by the illness, they have no cure for their conditions and patients slowly disappear in their illness – illness that is humiliating and undignified in its effects. It transforms them into remnants of what they used to be. The term dehumanization is not inaccurate for what I saw in the hospital.

Misery anchors the frail and inert bodies of the patients in this world. It also numbs and desensitizes anyone who spends some time here and fuels the intensely felt need to escape from there. The sheer fragility of human life is stripped of any glittering glamour and reduced to waiting for the end. However, there is also something incredibly crystalline and truthful about these unvarnished states that lack



any of the adornments of sophisticated contemporary life and the world behind the walls of the hospital. Stripped of the garments of social distinctions and having their unique life trajectories covered by clothes full of holes leaves the patients exposed. The only realm of freedom – their inner life – remains inaccessible from the outside. Leaving the walls of the hospital makes me wonder which of the two worlds is more true.

The medicalization of misery and hopelessness provides mechanisms to somehow normalize these states. The rituals of ward rounds, admission interviews, daily reports, as well as coffee after lunch help to alleviate the feeling of hopelessness which permeates the space. These rituals have another function, though: they keep the sense of solidity, of permanence, something that organizes and structures otherwise rather chaotic present. In the same way the space of the hospital accommodates patient after patient, coming and going, and remains unaltered as the days, years and decades pass by. The nurses and doctors keep busy and most of the time they are preoccupied by daily chores, administration, and phone calls, which all have their place in the daily schedule.



Medication cabinet and the list of mental disorders in the nurses' room, Kosmonosy hospital, 2007

The aim of psychiatric knowledge is to identify various aspects of the person that has been affected by the illness, using categories that allow us to conceptualize it and direct the appropriate algorithm of treatment. Like any abstraction the concept of mental illness of course does not capture the unique personalities and life histories of those suffering from such conditions. The person becomes a representation of the attributes of the illness and easily disappears in the bureaucratic system of the institution. The system deals with the disease more than with a person: the doctors spend much more time evaluating laboratory and imaging methods results, writing diagnostic reports and managing the conditions of patients rather than talking to them. The most tangible result of their work is the detailed documentation – not healing which in these cases is rarely attainable. Most nurses I met here consider their job rather unpleasant, dealing with yet another ‘admission’, ‘transfer’; or ‘discharge’. There is significant turn over among the staff since almost nobody who has other options would remain working here for too long. Returning to the hospital two years later I did not find there any of the young and middle-aged doctors and psychologists I was working with before. The institutional indifference is thus expressed both towards the patients and towards the staff: it is not important what kind of person they are, what matters is their ability to function in the system, fulfilling the administrative, medical and nursing tasks, and signing papers with appropriate stamps.



Patient's documentation in a doctor's office, Kosmonosy 2007

The numbness and dehumanizing conditions of the hospital were often reflected also in the behaviour of the staff and their comments on individual patients. I often observed a significant discrepancy between the interactions of staff with patients and their subsequent commenting on them in private. Some nurses often did not hesitate to use vulgar and rude adjectives when they talked about the patients. Some of the nurses were even referred to as SS-women by their colleagues for their sharp tongue and cruel manners. They often treated the patients as someone who does not deserve respect and whose behaviour (by doctors and psychologists more likely to be attributed to their illness) calls for some form of punishment rather than compassion. Some nurses would refer to the patients as dirty animals whose most appropriate place is in the cages (net beds). The chronic female ward was commonly referred to as a ZOO and some nurses would refer to themselves as a 'tamers of wild animals'.

However, despite the miserable and often demoralizing atmosphere of the hospital, the flashes of genuine human concern arise in the most unexpected circumstances. There were several exceptionally kind nurses who devoted all of their time and effort to the patients, trying to create more welcoming environment for them. One of the nurses was running a library as a space for relaxation, where she reads to patients and plays various games with them, offering them tea and coffee. Another psychologist established the horse therapy center and with admirable enthusiasm was developing new therapeutic approaches. Similarly, art therapy was introduced on the initiative of enthusiastic psychologists and nurses.

One of the curious things in the hospital was that most of the clocks in the ward hallways were either late or had stopped altogether. Although the daily rituals of ward rounds, meals in the dining room, coffees in the courtyard or in the smoking room and sometimes visits by family or friends seem to create some kind of rhythm, the overall sense is that in this place time is timeless. It is more like a common space that everyone inhabits. Despite this sense of being outside the time, the daily activities are actually very structured and each ward observes their regular schedule with meals, medication administration, ward rounds, and therapies, as milestones to the passing time.

### **Timetable on the Ward B1**

6:30 waking up

6:30 – 7:00 morning toilette, making of beds, tidying of bedrooms

7:00 – 7:15 morning exercise

7:30 – 8:00 breakfast, administering of the morning medication

8:00 – 8:45 community, ward round

8:45-10:45 work therapy, art therapy, library, horse therapy, CPT, LPT

11:15 – 11:45 lunch, administering of medication

11:45 – 12:00 washing up the dishes, cleaning the dining room

12:00 – 12:30 relaxation

12:30 – 13:30 rest

13:30 – 13:45 snack  
13:45 – 14:30 group therapy  
14:30 – 16:30 group walk  
13:30 – 16:30 individual walks  
16:00 – 17:30 cleaning the ward  
17:00 – 18:00 dinner, washing up the dishes  
18:30 administering of the evening medication  
19:00 – 21:30 free time  
21:30 – 22:00 evening toilette  
22:00 – 6:30 night rest

In all the wards the day starts with a ‘community’ – a meeting of all patients and staff in the ward. Here they discuss issues from the previous day, plan for the day or weekend, welcome the newcomers who have to introduce themselves – where they are from and what their interests are – and say farewell and wish good luck to those who are to be discharged. The atmosphere of these meetings is very different on the individual wards – ranging from a very relaxed meeting where the doctors and patients were passing a guitar and singing some songs to start the day, to a rather strict and tense atmosphere where patients had to stand up to welcome the staff and were not allowed to talk without raising their hand first. In some of the wards patients are encouraged to share their ‘therapeutic advances’ from the previous day, whereas the more difficult wards the doctors were trying to sort out complaints and arguments of patients who had difficulties getting along with each other, and often also to resolve some of the daily little thefts occurring on the ward.

In the community meetings the nurses and doctors also make the decisions of who is eligible for individual walks in the afternoon, who can go for a group walk with a nurse, and who has to stay in the ward. They also plan for the weekend – who can be discharged to see their family and who stays in the hospital. Occasionally, the local NGO, Focus, organises a trip to various places of interests (the ZOO, the castle, or a hike in the mountains) to which the patients are invited and these are also

announced at the meetings. Finally, the patients decide on how they will share the ward duties and chores among them – watering plants, cleaning the rooms, bathrooms and common spaces, washing the dishes, emptying the bins, etc. Although it might seem rather curious that patients are expected to clean and take care of their wards it has been argued that these chores help them to be responsible for their common space and contribute to the community feeling. It is like at home, some nurses say. The emphasis on work as a useful activity has a long tradition in this region and is considered a therapeutic activity – a similar approach was taken in the community housing I visited where the clients would additionally also cook their own meals and do groceries. The patients who are used to taking care of animals or have their own gardens at home tend to prefer to spend their time weeding the gardens, raking leaves in the park, or working on the farm. As we crossed from one building to another on a rainy day, the medical director regretted the mud sticking to our white shoes. He mentioned that until recently the paths have been taken care of by one of the patients who carefully collected stones to prevent mud from collecting in the holes. This patient, who died recently, considered it a great honor and a source of pride to take care of the paths, spending the days looking from his window to see whether the rain is coming. He was one of the last lobotomized patients we had here, the doctor told me.





Horse therapy on the farm, Kosmonosy hospital 2010

Once the scheduled therapies for a day are announced at the meeting – usually art therapy, horses, ceramics, candle making, library, work with textiles – patients can express their interest in these activities. There are also regular group therapy sessions, intended for patients with similar diagnoses, and it is ultimately on the doctors to decide which of the therapeutic activities are most appropriate for each of the patients. Some of the therapy is much more individually tailored. For example, one repeatedly hospitalised patient was a painter and poet suffering from schizophrenia and she was given as much freedom as she wanted to work on large canvasses and oils in the atelier. The art therapy sessions are considered a unique way to express the inner world through images and the paintings of patients are then used as a point of departure for a therapeutic dialogue. The artworks used this therapy are also used as a decoration of public spaces in the hospitals. Often, these paintings are of dark, heavy colours, expressive and forceful, but some are also bright and joyful. These are then also used as gifts for important visitors to the



hospital – such as representatives of the ministry of health or local politicians or occasionally, a sponsor.



Painting by one of the patients in the conference room, Kosmonosy hospital 2010



The patients who are too unwell to leave the wards tend to lie in their bed for most of the day. Sometimes they will ask nurses to give them tasks to occupy themselves and fill the otherwise empty time – lining the patient's charts, stamping various official letters, and also preparing material for occupational therapy – wool, fabrics, papers. Others just fill it with conversations over cigarettes and coffee, sitting in the hallways.

Coffee and cigarettes – in addition to toilet tissue – are the most precious item as well as a kind of currency in the hospital. Patients would often ask strangers passing by for a spare cigarette. Sometimes the desire for cigarettes is to be blamed for the 'disappearance' of money from their fellow patients. Patients who have the most contact with the outside world – those who have relatives or friends visiting them and providing them with these treasures – are often desirable 'friends': there is a kind of social hierarchy established around the possession of coffee and cigarettes and to share these with someone is an expression of sympathy and appreciation. Sometimes patients who were given sweets and chocolates make special evening parties for their circle of friends.

There are special smoking rooms on the wards where patients gather and often spend most of their time. In some wards this purpose is served by a small courtyard within the large buildings with few plastic chairs and walls high enough to prevent potential escape. Patients are not allowed to smoke elsewhere in the ward and being caught smoking in the bathroom by the nurses can lead to the loss of privileges – going out for walks or attending a therapy session, for example. Often patients burn their fingers from the cigarettes and come to the nurses to get some ointment. There were also cases of patients providing a cigarette to someone who was in the cage bed and there were several cases of fire caused by the cigarette. One of the wards also had a recent case of a patient dying in the smoking room unnoticed. The smoking rooms tend to be unattended by the staff and some of them are actually so full of smoke that it is very hard to see anything inside.

For the patients, nevertheless, smoking seems to represent one of the very few remaining pleasures of life and they are willing to give up other things for that.

They exchange the little valuables they have – pens, notebooks, cheap jewelry – for cigarettes or a coffee. In one of the wards one of the nurses confided to me that the patients exchange cigarettes for sex. She complained that night shifts are especially challenging – having to try to pull them away in their beds or in the bathrooms is quite a hard task for the one or two nurses present. Other nurses also felt that patients are calmer when they are able to have a few cigarettes – they say there is less arguments and less violence among patients if they get their daily dose. In one of the wards the social worker decided that the best system to prevent these potential difficulties is to create a form of ‘cigarette communism’ – every month she would take some money from the patient’s income – mostly their disability pension that she is entrusted – and distribute among all of them their daily ration of five cigarettes.

Coffee is an equally treasured resource. Drinking it is supervised by the nurses (risk of burns) and on some wards there is a schedule when the patients can come to the nurses with their cups filled with grained coffee and have hot water poured over it – 6:00; 9:00; 13:00; 16:00. Again, those patients who have coffee tend to be flattered by other patients so that when the time comes they might get a share. Several patients told me that coffee and cigarettes are the only thing for which the life is worth living in this place.

The schedule of the day also extends to the opening times of the bathroom which in some wards is open for a limited periods every day – 6-7, 12-13, 18:30-21. Bathrooms have the reputation of being the most common place for suicides and at these times there is one nurse available to watch over patients using it. Moreover, various kinds of activities might be going on there – often encouraged by the rather unusual arrangements of space. Some of the bathrooms are large rooms with several adjacent showers and several bathtubs in an open space so there is really no privacy. There are patients who do not mind this and actually enjoy these communal baths as a great fun. However, I also encountered several patients – considered ‘problematic’ by the nurses – which refused to take off their clothes in front of the other patients. Most patients, though, become compliant as there does not seem to be any other

option. After each bath a patient would get a rubber stamp into their documentation: 'Washed, nails cut'.



Bathroom, Kosmonosy hospital, 2007

Cleaning the bathrooms and especially the toilets is the least desirable task from the list of chores and only rarely do patients volunteer for this: to collect hair and nails and other bodily remnants on the floor and clean the room which is often stinking of urine is not a pleasant task for anyone. Often there is an undertone of punishment when the nurses ascribe these chores to specific patients. However, cleaning the bathroom might be the only time to enjoy some degree of privacy and I encountered several patients who regularly volunteered to do it for this reason. In one of the wards a patient who – to the great disapproval of his fellow patients – enjoyed singing out loud was always eager to take the task of bathroom cleaning since it was the only space that provided him with freedom to express himself.

Some of the patients lack basic hygienic items – toothbrush, soap and toilet tissue – and to provide them with some, the social worker applies for 100 Kč benefit from the ‘donation account’ of the hospital. In some of the male wards there is also an issue with shaving: since a razor is considered a dangerous item there is a barber who comes twice a week to take care of the face and hair of the patients. The nurses explained that the only way around that would be to have electric shavers. However, they are too expensive and unaffordable for many – for hygienic reasons each patient would have to have their own – and none of the staff has the qualification to use them. Thus, the nurses have to ask relatives to provide regular contributions for the service of the barber. I came across the following letter by a social worker to a patient’s family:

Dear Madam,

Your husband has been hospitalized here since 10.5. and on admission your son provided him with 300 Kč. Since then he pays every week for a barber and currently his debt is already 320 Kč. Your husband would also like to smoke but he has no money to buy his cigarettes and is therefore able to smoke only if some other patients provide him with some. Please, if it is in any way possible, send some money to the hospital for him.

Yours sincerely,

A.V.

The hospital is reimbursed for the care by means of health insurance. Any needs of the patients that do not qualify as medical care are not covered by the insurance and the staff has to find other ways to provide for patient’s basic needs. The notice board of the waiting room where patients meet with their family members during visiting hours – usually two afternoons a week – presents the following letter:

Dear Madam/Sir,

This psychiatric hospital is a health care institution providing care for patients from three large regions and the demand for the services of our institution has been permanently increasing. Our aim is to provide complex nursing care in the best possible quality. Despite our effort to provide the highest quality of care our financial budget does not allow for obtaining some extra nursing aids for our clients.

Therefore we would like to ask you for your assistance in providing a better quality nursing care for your relative. We would like to allow them to use more disposable pads and liners. These aids are recommended for patients who have problems with

urination since they provide them with greater comfort and, more significantly, they also protect the skin. We do use these disposable liners and pads but unfortunately the insurance companies reimburse only three pieces a day.

We are therefore asking you a favour. If you decide to help us provide liners or pads for your relative, you can present these in the ward or make an appointment with our staff – a nurse or social worker – to discuss further possibilities. Of course it is entirely up to your willingness and ability to help. Whatever decision you make we will still try to provide the highest attainable quality of care.

With regards,

S.F.

Chief Nurse of the Hospital

Similar difficulties of scarcity are faced by the staff with respect to the clothing of patients. On admission the patients and their relatives are given an information sheet with the following options. They are supposed to select one:

Rules for the clothes of patients on the wards applicable for patients coming from the terrain accompanied by their relatives, and those who at least have a family or a guardian:

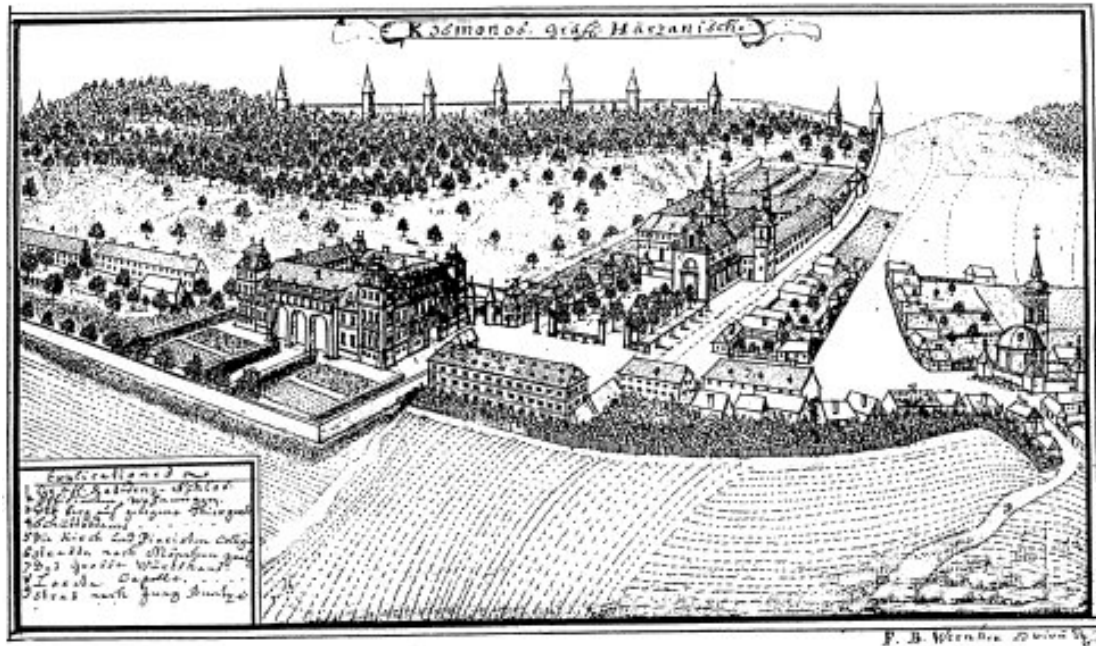
1. It is permitted to leave the patient's own clothes on the ward only on the assumption that the family will provide for its regular exchange and cleaning and at the same time acknowledge fully that with respect to the nature of the conditions of the other patients in this kind of hospital it is not entirely possible to guarantee that damage or loss will not occur. I agree.
2. It is possible to purchase new clothes which would be of the same kind as those of other patients on the wards. It will be washed here for him/her and at discharge these clothes will remain his/her possession. Even in such circumstances it is impossible to guarantee against potential loss or damage. I agree.
3. The patient shall obtain their clothes from the psychiatric hospital. These clothes are of the institutional type and for many it is esthetically unsatisfactory since it deprives the patient of their individuality and contributes to the image of the chronic wards in hospitals from the past. These clothes shall be washed by the institution and remain a property of the institution. I agree.

The family can make a decision. The issue of watches and jewelry shall be dealt with on an individual basis.”

For many patients in the chronic wards the third option become the reality. However, there is a lack of institutional clothes which also poses a limit to what patients are able to do while in the hospital. I have encountered several patients who were admitted in the summer and therefore had no warm clothes – no coats and no winter shoes – and once the weather got colder they were not allowed to go for walks outside as a result of their poor clothing. They inadvertently became prisoners on the

wards. Sometimes the nurses and doctors would bring their own used clothes and this is divided among the patients in the morning community meetings. Some of the doctors told me they prefer to leave the bags with clothes from their families on benches in the park so that they are not associated with them. One year the clothing situation in Bohnice hospital was rather critical as the harsh winter came and the director came with rather curious solution: the hospital made an agreement with the police to receive the fake brands clothes confiscated on the Vietnamese markets around the town.

## The Space and Order of Psychiatric Hospitals



Kosmonosy hospital, F.B. Werner 1752 (archive)

Kosmonosy hospital was originally established as an institution to take care of the incurable patients who were transferred there from the Prague clinic. The origins of state organised care for the mentally ill in Bohemia dates to the reign of the Habsburg emperor Josef II (1741-1790) and his modernising reforms in the regime of enlightened absolutism. Previously, the care of ill and poor was provided in hospitals and asylums established by monasteries and convents, most commonly the Misericordia Brotherhood – the community of Merciful Brothers. As a consequence of the renegotiation of authority and sphere of influence between the Viennese emperors with their state apparatus and the Church, Josef II established the Royal provincial orphanage in Prague in 1783, followed by an institution for the poor in 1784, an institution for the deaf in 1786, a maternity hospital in 1789, and a general hospital including a madhouse – Tollhouse – in 1790. It was this shift of authority from the Church to the State in the context of anticlerical reforms that resulted in the establishment of secular hospitals, although these were still often located in formerly religious settings (Tinková 2010). The madhouse was established

in a former monastery of the Merciful Brothers and at first was merely a place to accommodate the ‘enraged, dangerous and impure patients’ who were to inhabit the small monastic cells – supervised by wardens rather than carers. The chronicle of this institution states that at the end of 1791 there were 93 mentally ill, and of those 33 persons were discharged as cured, 17 improved in their condition, and 25 patients died in the course of that year. Writing on the history of psychiatric hospitals in Prague in 1926 Professor Haveroch sets the establishment of such an institution in a wider context:

“Among the most painful chapters of human misery and suffering, the fate of the miserable mentally ill was exceptionally harsh, most significantly in those whose illness grew to the stage of madness and rage. These unfortunate were to be found in large and small villages likewise and there was no neighbourhood where such miserables would not wander around. These were the ‘silent mad’ who were targets of the laugh and provocation of the naughty young. Much harsher was it for those whose outbursts of mad rage endangered the property and life of others and of whom others thought that they are possessed by the Devil. Those were treated insensitively, cruelly, viciously. There was no compassion for those and they were locked into dark holes without air and light, restrained by ropes and chains, perished in dirt and impurity, suffered multiple wants and the adversities of weather. These were the real martyrs whom only merciful death would introduce to the kingdom of rest and peace. This is how things were for long ages. Only during the reign of Josef II, the larger merciful institutions were introduced to alleviate various kinds of human misery.” (Haveroch et Frabša 1926)

Haveroch’s account also signifies the shift in the understanding of mental illness from the ‘religious’ or rather ‘superstitious’ interpretation of madness as a sign of evil to the more ‘naturalistic’ explanation in terms of disease. These are post-Enlightenment motives – the secularization of the interpretation of nature as well as the emphasis on the role of the state in welfare issues. In 1811 the institution was entrusted to the Prague professors of internal medicine and the asylum transformed into a hospital. Professor Haveroch describes the situation in the institution:

“Both genders lived here together, and the calm and auspicious patients suffered enormously from the tumultuous, decrepit and impure, so that even curable forms of psychosis found here were to become permanent and severe. It was therefore impossible to close one’s eyes to the categorical necessity to make some order in the institution. At first they vacated several rooms in which they accommodated the calm patients. This solution nevertheless offered only temporarily relief and the directorate



of the hospital decided to act upon the imperial offices – however financially unwelcome – to seek a more suitable accommodation for the mentally ill. In 1822 the premises of the former Augustinian monastery of St Catharine were rented for this purpose and the first independent institution was thus established. The increasing number of mentally ill individuals and the first signs of a new stream in medicine – psychiatry – caused the shift from merely nursing the patients to treating them and the conditions would be arranged for patients to find a cure. For this purpose the former monastery of St Catharine was considered appropriate and was thus bought in 1826. The larger building was intended for men, the smaller for women, both of these were divided by a courtyard and surrounded by gardens that were enclosed by high walls. The courtyard was later adjusted to allow for a flower and vegetable garden. On the ground floor of the large building was a kitchen, an apartment for the cook and warden, four little rooms for individuals, a large hall (a former refectory) and six rooms of medium size. The last one was transformed into a bathroom with showers.”

There are several interesting motives in this description. First, the emphasis on the spatial order of the hospital that was to contain patients suffering from mental illness and, analogously, the order that was to govern all aspects of their lives. This is something that was taken over once psychiatric hospitals were designed *de novo* at the end of nineteenth century. Second, the distinction between the ‘curable’ and the ‘incurable’ conditions, and this segregation of the patients has also significantly influenced the organisation of the hospitals as well as therapeutic approaches.

The first director of the hospital was Professor Josef Riedel, who served in this post until 1851 when he was invited to Vienna to design and direct a new hospital there. The hospital soon became overcrowded and had insufficient means to provide for the large numbers of mentally ill in need of care. Dr. Riedel thus negotiated with the provincial committee that a new hospital be built to accommodate all the patients and also allow for new therapeutical methods to be used for their benefit. This hospital was opened in 1844 and consisted of a main two stories building facing the town for calm, curable and clean patients, and two one story side wings for enraged, agitated and impure patients. The socioeconomic status of the patients was also reflected in the spatial order, since the three classes (I, II, III) of patients were accommodated on different floors. This new building was therefore established as a ‘therapeutic institution’ for those for whom there was at least a slight spark of hope for improvement and healing. The former monastery remained a

‘caring institution’ for agitated and impure patients with little hope of improvement, with separate spaces devoted to enraged patients and the epileptics.

The spatial order thus reflected the ideas about the nature of the various forms of mental illness. Dr. Riedel was influenced by the German Psychiatrist H.P.A. Damerow who advocated a holistic approach to treating the mentally ill: the patient is a union of body, soul, and mind and this was to be reflected in the therapeutic approach as well. In contrast to earlier methods of restraining the patients and expelling the illness through often violent practices, he greatly emphasized the importance of a protective environment that would *‘comfort every patient that came here tossed and worn down by their civil life in the outside world’*. As a proponent of the somatic school he viewed mental illness as an organic (biological) pathology and therefore various physical and pharmacological treatments needs to be used (among these were also water therapy and electrical therapy for epileptics). However, the role of the environment was also emphasised in this approach: in order to recover the organism needs to regenerate its strength that is exhausted by the illness processes, and therefore the right nutrition and protective environment is of crucial importance. He advocated the calming effect of the structured life in the secluded institutions where the patients were encouraged to participate on activities that would distract their mind from the delusional ideas and elevate the spirit. The most important role in the therapy was nevertheless attributed to work that grounds patients in ‘reality’. In his diary dated in 1829 Dr. Riedel gives rather vivid description of activities taking place in the hospital:

“By the hands of the ill, four gardens are cultivated, one orchard, two vegetable gardens and a park. The ill participate in the care of their home, clean the hallways, chop the wood, and carry the water. The women sew and stitch, knit, embroider, work in the kitchen, clean the rooms. The craftsmen work in their workshops in various trades – for example as a tailor or making shoes and gloves. The more educated spend their time as scribes, learning foreign languages and even working in literature. The experts continue to work on their beloved subjects: herbal and mineralogical collections. These preoccupations have very beneficial influence over those whose sense for any physical or mental work is seemingly stupefied. It is therefore clearly desirable that every ill patient according to their individual interests found occupation adequate to their strength, taste and interest, so that we would have all the various workshops, ateliers for the artists, libraries and museums for the

scholars, so that the world of delusions that captured the spirit would lose its strength when faced with the real reality.” (Riedel in Haveroch et Frabša 1926)

Dr. Riedel emphasised not only the practical benefits of such arrangement but also the improvement in patient’s state of mind and their social life:

“The feeling of helplessness and despondency disappear when the patient is praised for their work and see that they are actually capable of beneficial work. The lack of confidence and the fear from life after discharge temper and trust grows. Volatility and hesitancy are subject to the order of obligation to do certain work and the persistence and resilience is strengthened. Working together with others also smoothes the rough and thorny behaviour of the asocial ill who then learn to bear the weaknesses of others with greater patience and leniency. The common endeavour makes the patients become close and gives stimulus for friendship.”

Dr. Riedel also negotiated that the hospital will employ the more educated among patients in various offices, and argued for a ‘fair reward’ for the work of all the working patients. The money earned by work was then saved in a bank and used for buying new clothes and presents given to the patients for Christmas, for various artistic productions and balls, excursions, music scores, as well as to support the poor discharged from the hospital. The reward was considered not only a matter of justice but also a therapeutic instrument and a kind of life for the patients who by virtue of their work became ‘useful citizens’:

“The longstanding endeavour for the most extensive and efficient realisation of an ideal to build an institutional organisation that would as closely as possible reflect the civil organisation of hardworking and useful citizens thus came to bear fruit.”

In late 1840s a new colony was established in nearby premises of another vacated convent Na Slupi. The extensive land belonging to this convent was used for agricultural activities. Patients were growing vegetables and fruit. The hospital also provided entertainment and artistic activities: there was a large hall with a piano and a billiard for social events, dances, concerts, as well as a gymnasium for sport and physical exercise. There was a music ensemble consisting of both patients and carers which gave an hour long performance for the patients every day. There were also several attempts to provide education where the more educated among patients tutor others in arithmetics, geography, history, and engage them in various activities to improve memory. This school provided tuition for five hours every day, and the

patients were singing together in the beginning and end of every session. The physicians also organised various excursions and trips for the patients to attend concerts, theatres and exhibitions with the aim to distract patients from their preoccupation with delusions. However, these activities were mostly provided for the ‘curable patients’, and it is also rather likely that some of them were limited to members of the ‘higher classes’. The Prague nobility was invited to their annual balls and performances and some of them then offered to sponsor the institution. The patients – although only those who were calm and well behaved as ascertained by the letter from their doctors – also regularly attended services in the chapel that had remained to serve its purpose since the monasterial days. The documentation nevertheless stressed that the ‘incurable patients’ and their need for social contact should not be neglected.

Retrospectively it is impossible to judge how realistic these accounts actually were and also to what extent the idealistic description obscures more pragmatic aspects of the whole project. In some reports found there were complaints about the use of parks and garden that were worked on by the poor patients for the benefit of wealthy patients who were the only one to have access to there, and it seems that the world in the institution reflected the social divisions present in the outer world. Nevertheless, it seems that the ideas on the life of the community do represent an ideal that the hospital aspired to.

However, the conditions of the hospital seemed to deteriorate as a result of the political situation – the clinic was divided into German and Czech parts in 1886 and a significant proportion of the premises and orchards were sold by the Royal Provincial Commission, so that the hospital lost almost all its gardens and land. It also seems that the conditions for the staff worsened and it was getting more difficult to find appropriate people who were willing to kindly provide care in a rather challenging environment.

The intriguing line drawn between the curable and the incurable is a phenomenon that to certain degree is relevant even in contemporary psychiatry. However, the spectrum of conditions that are treatable or curable and those that are

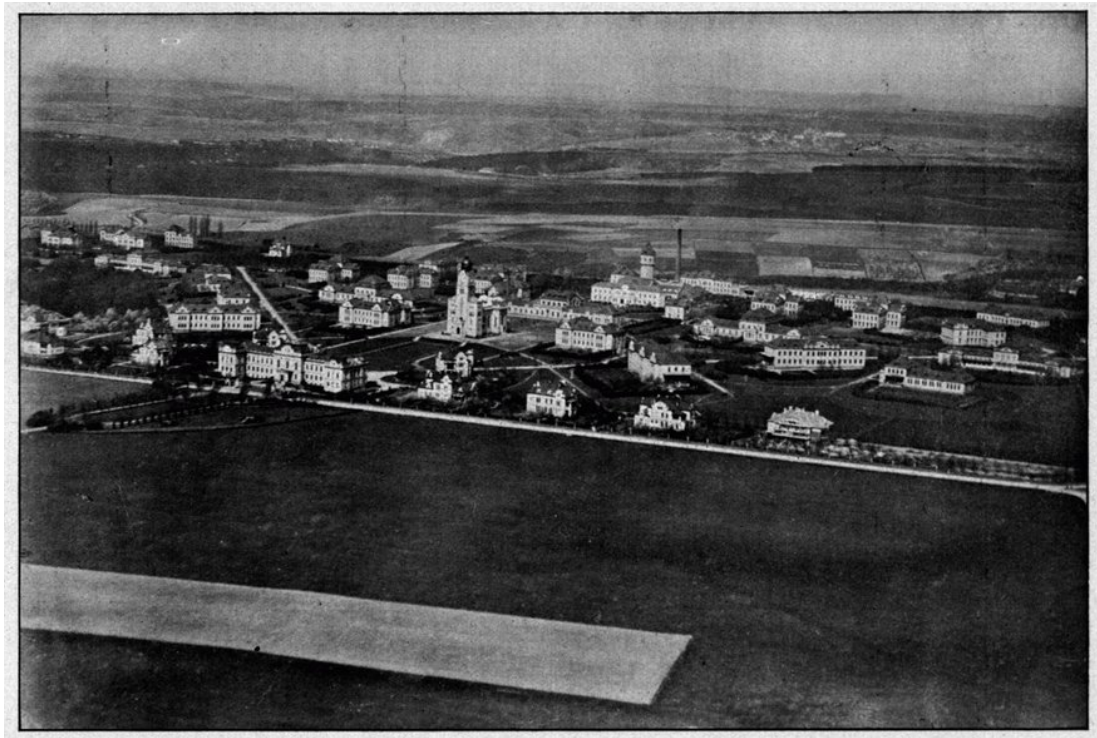
not has likely changed since the early days of these hospitals. Before the advent of antibiotics many patients with psychiatric symptoms suffered late consequences of infections diseases like syphilis or tuberculosis that affected their nervous system. There was nevertheless an idea that early treatment improves the chances of healing and the longer the patient suffer from their illness the more likely are they to become incurable. The order by the governor from 1882 regarding the 'timely delivery of the mentally ill to the humanitarian institution' (as the hospitals were then called) reads: "The regional governors should educate their people so that the mentally ill are delivered in a timely matter to the institution, while there is still hope for their recovery and not just when they are already incurable. By this the madhouses become merely custodial institutions and their therapeutic task becomes entirely illusory."<sup>134</sup>

This seems to suggest that early commencement of therapy was considered a principal factor for the success of treatment. Only time can show whether the progression of disease or recovery will take place. The patients who did not recover were deemed incurable and were transferred to special hospitals, such as Kosmonosy, to make space to accommodate other patients in need. The overcrowding of hospitals in Prague has been a persistent phenomenon.

With growing industrialization and large numbers of peasants moving into overcrowded suburbs of towns in search for work, the care of family members who have succumbed to mental illness was even more difficult than in the villages. The government had to respond to the changing social and economic conditions. The Bohemian Royal Provincial Commission established several large hospital complexes to take care of mentally ill patients and accommodate those for whom the family was unable or unwilling to provide care. The whole project was planned centrally from Vienna for the whole empire – and therefore similar hospitals are found in all other regions of the former Austrian-Hungarian lands. The ideas embodied in the spatial organisation of the hospitals were influenced significantly by Dr. Riedel and his teaching on the therapeutic environment that is of great significance for the recovery of patients suffering from mental disorders.

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<sup>134</sup> výnos místodržitele pro království České ze 10.VII.1882



Bohnice hospital, photograph from 1920s (archive)

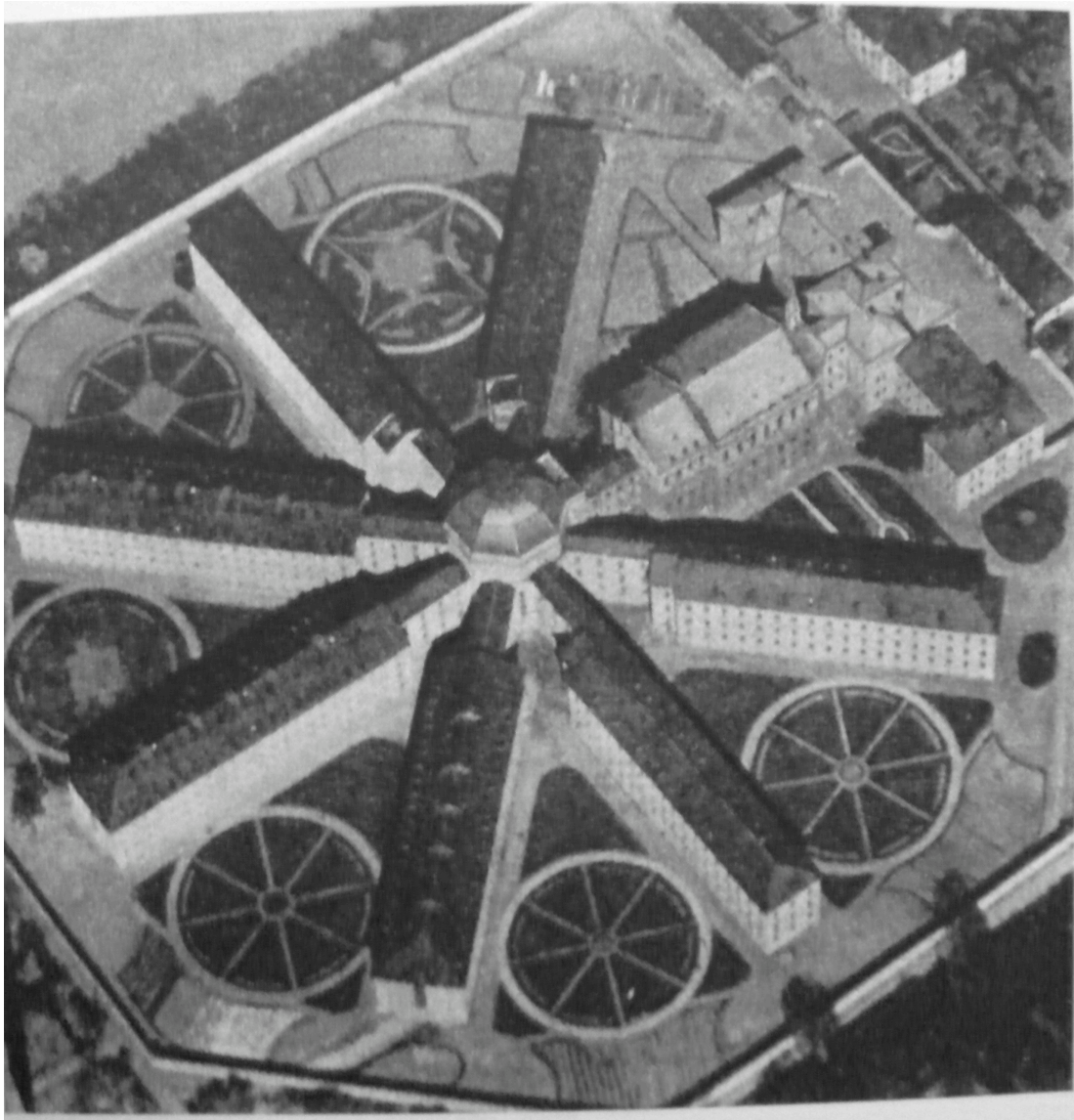
To serve the district of the municipality of Prague, a large hospital complex was established in Bohnice *‘to provide mentally ill with healthy environment and modern humane care’* (Wallenfels 1926). In that time, Bohnice was just a small village in the fields north from Prague, and the Royal Province decided to buy extensive farm land and build a hospital for mentally ill who could not be accommodated in the Prague hospital. Several famous architects participated in the competition for a large and high-profile project and the winning proposal was that of V. Heller and J. Deport, with a special prize awarded to V. Roštlapil – who also designed government headquarters, Straka Academy, the Academy of Arts and other representative buildings. The hospital complex was designed as a large park, arboretum, with spacious villas in the fashionable art-nouveau style scattered in geometric fashion around the centre with a monumental Church of St. Václav – Wenceslas – the patron of Bohemia. The landscaping was truly grandiose and the engineering of the facilities and their technical equipment very progressive for that time. The interiors of individual villas were functional in their use of space and of

modest appearance. Nevertheless, the administrative building and the pavilions for wealthy patients were rather extravagant with a high standard of comfort and fashionable style. Enclosed within walls, this self-sufficient complex was to accommodate the community of people suffering from mental illness and those caring for them.

According to Jindřich Vybíral, historian of architecture, the design of the hospital space embodies the idea of separation, differentiation and classification – the ‘icons of the modern era’ (Vybíral 2002, p. 202). Commenting on late nineteenth century architecture he notes that with the emergence of urban society anonymity was a prominent characteristic of the newly evolving social order and this was reflected in the organisation of urban space. The guiding principle of spatial organisation, order, was nevertheless constantly under a threat to become disorder. The potential violation of social order thus needs control mechanisms to protect it from dissipation, and the state developed various mechanisms to prevent and remedy such disorders. As Michel Foucault demonstrated in his studies of the formation of discipline society prisons and mental hospitals played a special role in this process (Foucault 1995; 2006). Despite their many significant differences, prisons and hospitals built in that time shared some common characteristics: Vybíral notes that both prisons and hospitals were designed as ‘buildings without a facade’. ‘Homo criminalis’ and other undesirable persons – people without a face – were to be secluded and the buildings dedicated to their isolation and improvement should not have a face either. The undesirable elements had no space in the new order of society, and thus had to be accommodated well beyond the walls of the cities.

One example of the ideal design for prisons in this era was the Panopticon designed by the reformer of criminal law in Britain, Jeremy Bentham. This design served as a model for several institutions throughout Europe: a symmetrical polygonal building with a central tower and multiple radial projections that consisted of long halls with entrances to the individual cells. In Bohemia two large prisons were built in this fashion – Pankrác and Bory – in the proximity of two large towns, Prague and Plzeň. These were the same towns that accommodated the largest

psychiatric hospitals in their vicinity – Bohnice and Dobřany. The central tower of these prison buildings consisted of a large hall with seven radiating wings which were to accommodate the convicts, some of them as individual cells, others as large rooms for several of them. The eight radii connected the centre with an administrative building, classrooms and a chapel, and continued to the front buildings serving as a hospital and accommodation for the wardens.



Bory prison, early 1900s (archive)

The architectural design of the psychiatric hospitals nevertheless differs significantly from the design of prisons or military barracks, as Jindřich Vybíral notes

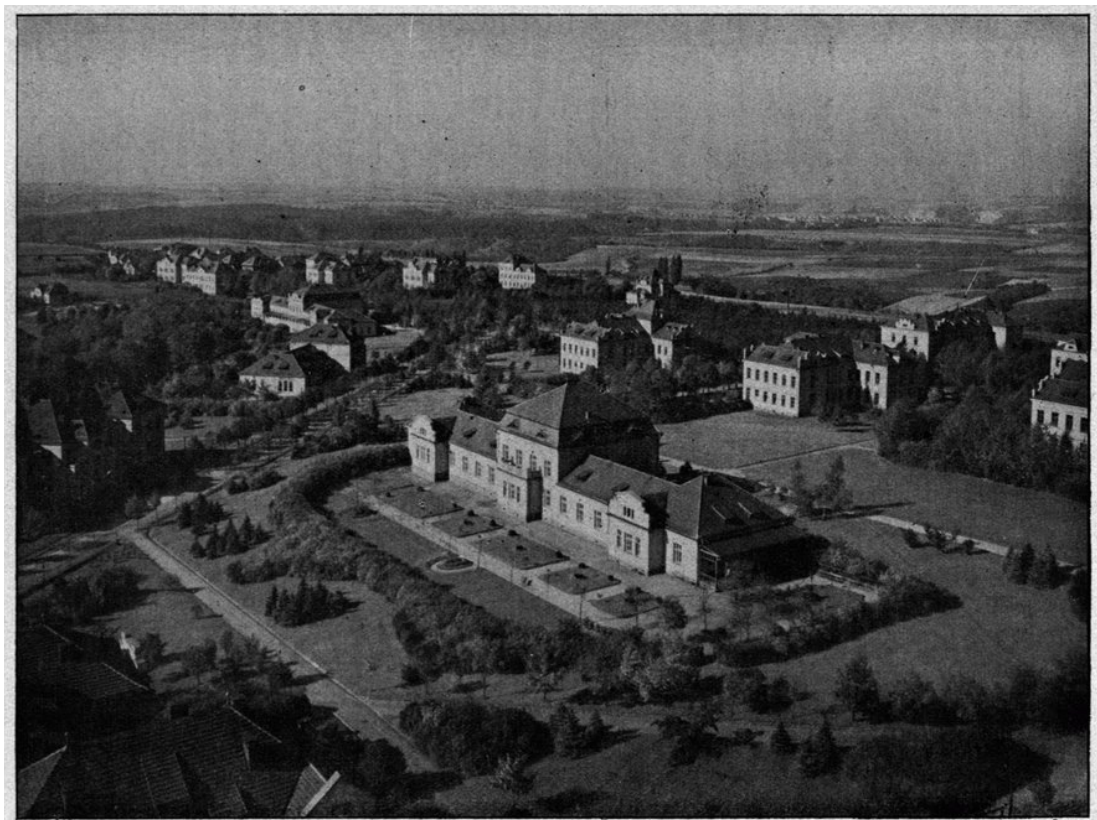


in his essay. In contrast to the uniform architecture of the prisons, the hospitals were supposed to give impression of a welcoming refuge, almost as large country houses. The hospitals were designed as a large parks with villas scattered in a geometric fashion around the central axis, and it has to impress as a place of calm, refuge and home. This axis consisted of maintenance buildings as the backbone, the chapel as the heart and the administrative building as the head of this huge complexe. The whole complex embodied the idea of organic community. By emphasizing this aspect of the architecture of psychiatric hospitals – order and community – Vybíral challenges Michel Foucault who considered the hospitals an expression of the disciplinary order of society with unequal distribution of power. He emphasizes the motive of order as an expression of modern rationality that was the guiding principle of the organisation of the state as well as medicine and especially the medicine of the soul or mind, as psychiatry was then understood.

“The prisons and hospitals are not expressions of the disciplinary society which aim for the generalizable mechanism of panoptism. Rather, the regular and symmetrical order as well as the functionality and simplicity of facades are a manifesto of modern rationalism which prefers clarity and distinctiveness. This geometry then represents a way to bring the human works to harmony with the principles of the universe. Symmetry, measure and proportion – according to the theorists of French classicism – are attributes of order that contrasts and combats the chaos of unlawfulness and madness. These are the quarters of Reason which has to conquer its enemies.” (Vybíral 2002, p. 204)

In contrast to the prisons the psychiatric hospital followed taxonomic order: the key determinants of the spatial organisations of the hospitals were the gender and age of the patients, type of disease they suffered and its severity, and often also their social background. These characteristics functioned as a key to locate individual patients to the respective buildings and defined their place in the therapeutic universe. In Bohnice hospital, there were 28 villas set out in a mirror fashion around the main axis: one side was devoted to the accommodation of male and the other of female patients. Two of these villas were designed for the admission of patients, two villas for calm patients, two for ‘less calm’ (i.e. agitated) patients, eight for ‘uneasy’ patients, two for patients that required to be cared for in their beds, two for ‘contaminating’ or ‘unclean’ patients, two for patients affected both by physical

and mental disease, and six for patients that were well enough to be engaged in maintenance works. Each side of the complex devoted to one gender was additionally divided by diagonal paths that set apart buildings for the three classes of patients accommodated here – smaller villas for the class III patients and more fashionable large villas for the class I and II. Vybíral claims that the social and spatial environment of the hospitals embodies the fundamental ambivalence of protection and isolation that reflect the atmosphere, attitudes and values of the society, namely that of the late Austrian-Hungarian Empire.



The western part of the Bohnice hospital viewed from the Church, early 1900s (archive)

This emphasis on reason and order resonates with the classical study of the origins of psychiatry in France, *Console and Classify*, by the historian Jan Goldstein (Goldstein 2001). Goldstein argues that the Enlightenment ideals of rationality and kindness were the key motives in the establishment of psychiatric profession in nineteenth century France. It was the idea ‘moral treatment’ with the emphasis on a humane

approach to the patients and the importance of appropriate therapeutic environment and as well as that of descriptive psychopathology that informed the architecture of psychiatric hospitals in this era.

The central axis of Bohnice hospital that divided the male and female part of the hospital also connected the public and work facilities: a large administrative building with the director's office, representative hall, libraries, visitors rooms, admission offices and the telephone central and a pharmacy; the church; the kitchen which provided daily meals for 2,700 persons; the laundry (120,000 garments were washed every month); central bathroom/spa (14 tubs) and a water tank; electricity plant; heating plants; disinfection facilities (to disinfect linens and clothes from the infectious and admission wards); and various workshops – carpenter, joiner, painter, whitesmith, tailor, shoemaker, upholsterer, mattress makers, locksmith, etc. – and storage facilities. One of the buildings also entailed large theatre and concert hall for social events and an extensive library.<sup>135</sup>

The hospital was planned to accommodate 1,774 patients but already in 1937 their numbers reached 2,567. Writing in 1925 its director Dr Wallenfels concluded his account of the hospital with arguments for the expansion of the care:

“Bohnice hospital is quickly approaching the time where the numerous pavilions would not be able to accommodate the flood of patients. Since we are not willing to return to the situation of the institutions some thirty years ago where the conditions went against all the humanity, irrespective of the financial difficulties it is necessary to fulfill our human duty towards the most unfortunate and by building new institutions relieve them and their families the fate which is already very bitter.” (Wallenfels 1926)

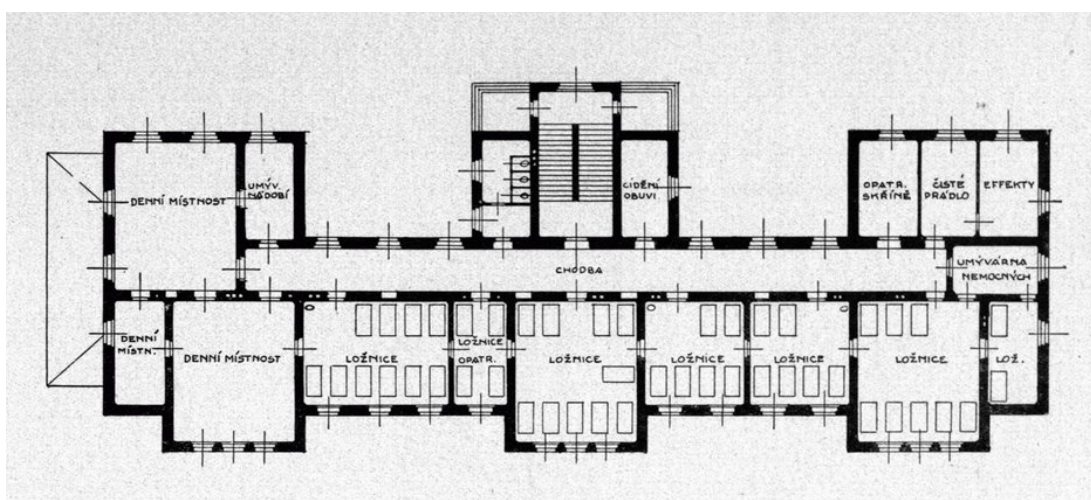
The most western part of the complex consisted a large farm with gardens and orchards, as well as a colony of houses for agricultural workers and working patients. At the northern part of the complex one villa was isolated from the others by high wall and served for detention of criminals, and another one which served as isolation unit for those suffering from tuberculosis and other infectious diseases. In an ‘appropriate’ distance (not too far, not too close) from the northern wall the

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<sup>135</sup> In 1949 there were 36 treatment buildings for patients; 44 buildings for accommodation; 46 buildings providing facilities for auxiliary medical, technical and works including 27 different workshops; farm and garden of 70 ha; and a cemetery. The overall size reached 800 ha.

mortuary was built with a small room to exhibit the dead and allow for the final farewell, as well as a laboratory space where doctors performed autopsies and engaged in research.

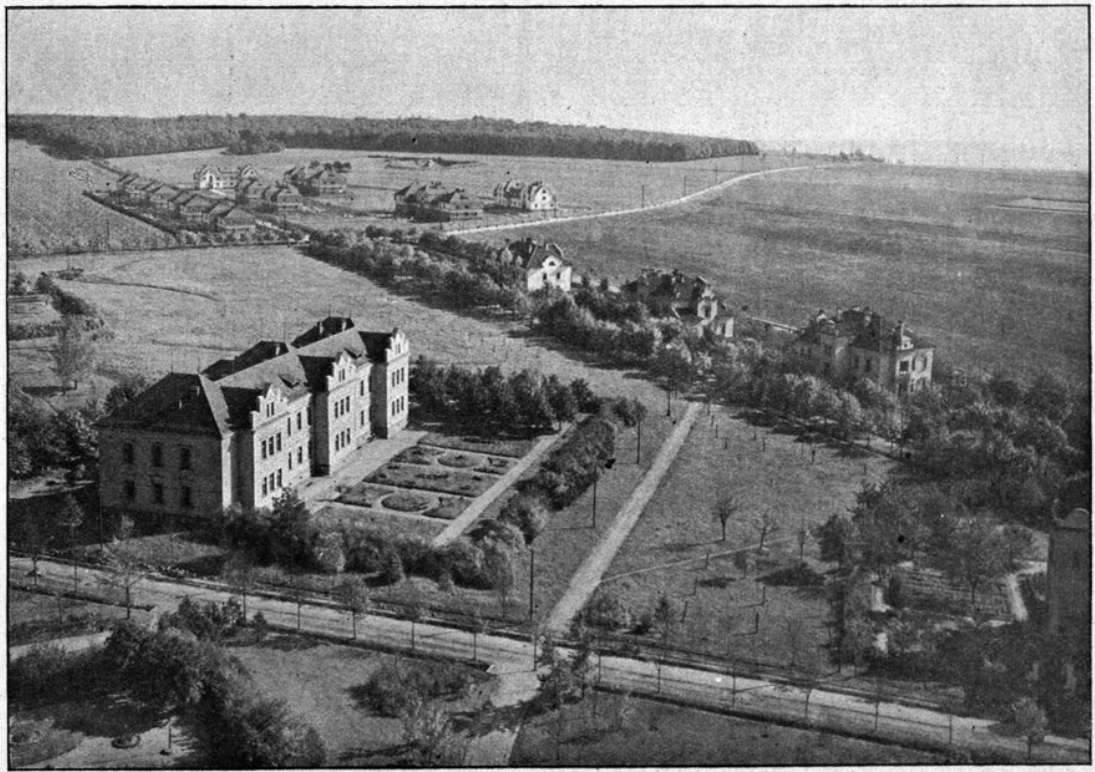
On the southern side of the complex were villas for the director, medical doctors, nurses, administrators and other workers, and later two other colonies in neighborhood areas were built for this purposes.<sup>136</sup> In 1925 there were 15 doctors, 1 priest, 19 accountants, 6 administrative officers, 2 agricultural officers, 1 pharmacist, 1 technical officer, 194 workers and 671 carers to provide for 2036 patients.<sup>137</sup> The life of the staff was also strictly regulated in pre-war times: they were allowed to leave the premises only for one afternoon a week, had to be granted a special permission to leave for the night and report where they spent the night and with whom. Everyone living on the premises of this hospital was subject to the strict order of the institution. The doctors also lived on the premises and they earned the same salary as porters; the nursing staff as well as other manual workers got about half of the average wage of servants in that time (Tichý 2006). Each of the doctors was responsible for one or more wards, and for each ward with 45-70 patients there were seven nurses providing care.



Outline of rooms, pavilion for calm female patients, Bohnice hospital, early 1900s (archive)

<sup>136</sup> 44 houses with 320 apartments in 1949.

<sup>137</sup> Currently there are 1300 patients and 1100 staff working in Bohnice hospital (2008).



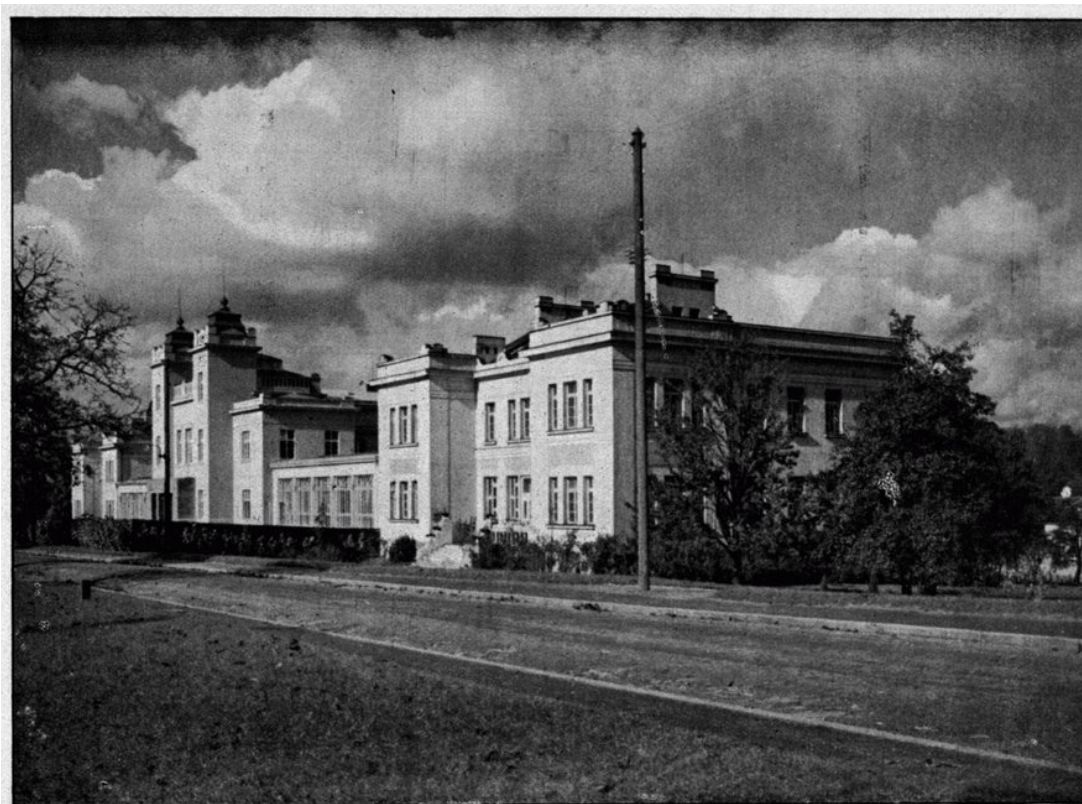
Pavilion for calm female patients, Bohnice hospital, early 1900s (archive)



Room for calm female patients, Bohnice hospital, early 1900s (archive)



The first book of guidelines for psychiatric nursing was published by the first medical director, Dr. Jan Hraše, who later worked in another large hospital in Dobřany. The author addressed not only the technical skills of the staff but also ethical issues arising in dealing with patients suffering from mental illness. This book offers insight into the practices of psychiatry in that period, including some of eugenically motivated practices that were quite widespread. (Hraše 1905; 1916)



Theatre building, Bohnice hospital, early 1900s (archive)

Both patients and staff participated on various cultural activities: the hospital had its own theatre and music ensemble. Patients capable of work actually participated on the construction and maintenance of this spectacular complex: as in Dr. Riedel's description from a century earlier, work served as both meaningful utilization of time and contribution to the common good in once. It was also understood as a form of therapy – a form of care for oneself and ultimately also for

others with whom they share this community.<sup>138</sup> Patients participated in construction works, on farming, gardening, worked on fields and vineyards – they even worked as gravediggers and carpenters manufacturing the coffins (Tichý 2006). This large hospital complex thus encompassed all aspects of life and death, and developed a whole social economy as a world of its own.

Nearby the hospital complex a cemetery was established with chapel and morgue. The hospital was also responsible for burying the dead who did not have any known relatives. This was also an extensive park with 4100 graves. There are no names on the graves, just numbers.

The cemetery is not in use anymore. The last acquisitions' of this cemetery were the bodies of Italian Soldiers from a nearby camp during the war and after World War II. After the war, the hospital cemetery became included in the municipal organization of funeral services, and in 1963 appropriated by the Prague funeral services (Nekvasil 1946). Currently the cemetery is closed, inaccessible and in decay. The chapel was dismantled by someone who considered its stones and woods still useful as building materials.<sup>139</sup>

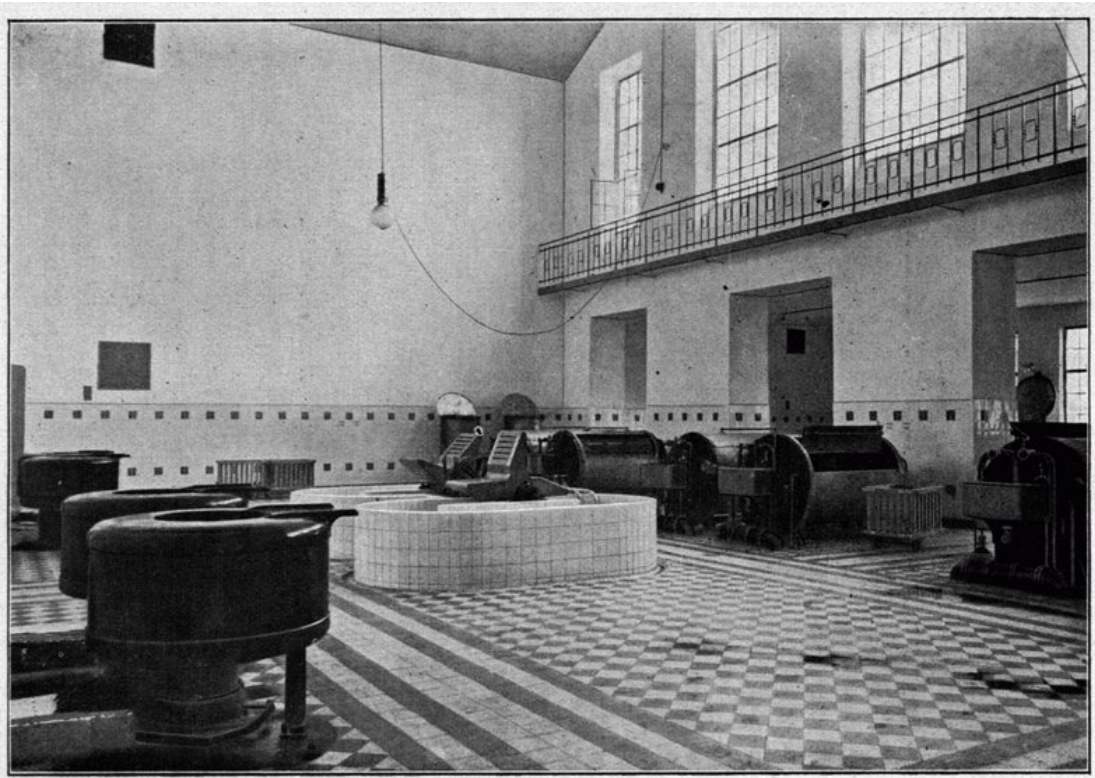
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<sup>138</sup> This is not unlike the situation in Terezín some forty years later where people of Jewish origins were transported to the Terezín ghetto – a work colony – to build a concentration camp for themselves. After the war Bohnice hospital was partially taken by the military and in 1950 the government decided to use the premises as a whole for air force barracks and transfer psychiatric patients in the 'vacated' Terezín. Due to the lack of capacity for patients elsewhere the hospital was shared by the military and patients until 1956 when this decision was overruled and the buildings returned to the hospital, while the military retained only very few buildings, among them the church of St Wenceslas used as military storage.

<sup>139</sup> In a rather curious contrast, just opposite to this cemetery in 1998 a pet cemetery was opened. Within first eight years of existence embraced the bodies of more than 2000 animals, mostly dogs, cats and parrots (who are often buried together with pieces of jewels, gold, and bottles of champagne). As the piece of land on which this cemetery is established is formally a park the gravestones were originally not permitted and instead on each grave is planted a bush or tree by the grieving family, and *"the soul of the animal transforms into the life of trees"*, according to the founder of the cemetery. In 2007 the dispute over the ownership of the land threatened its existence and the former dog owners wrote a petition to the Ministry of Agriculture. The Ministry then instituted a legal proceeding against the land property fund as the minister considered the park as a *"good idea: the tree reminds people of the faithful animal, and the memory is alive forever."* The names are now inscribed on the stone gravestones, decorated with ornaments, sculptures and inscriptions. The park was saved although the capacity to welcome bodies of deceased 'faithful friends of people' was reached. The place is now called 'European Park of Piety' and the website of the cemetery mentions that pets of many famous people are buried here, including the dog of Václav Havel and various diplomats. The site opens with a following motto: *"If there are no dogs in heaven then after I die I want to rather come to where they are"*.



Laundry building with water tower, Bohnice hospital, early 1900s (archive)

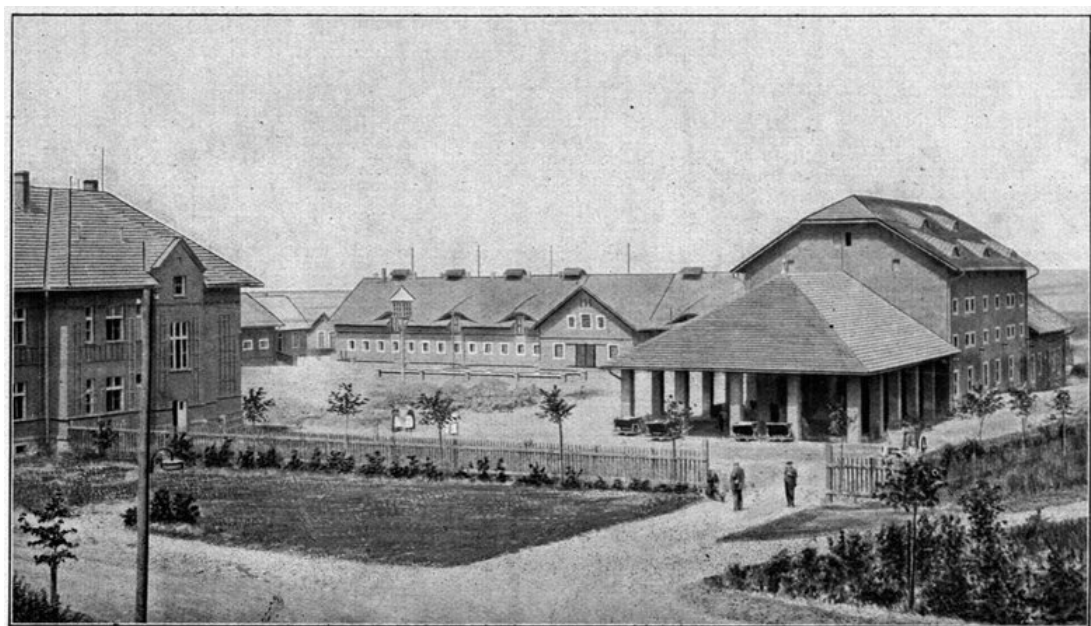


Laundry building, Bohnice hospital, early 1900s (archive)





Kitchen, Bohnice hospital, early 1900s (archive)



Farm and agricultural buildings, Bohnice hospital, early 1900s (archive)

## Liminality – Here and Beyond

The architecture of psychiatric hospitals and the classifications embodied in the organisation of the space set apart the world of hospitals from the urban surroundings that they became part of with the expansion of cities during the course of the last century. Time still has a different pace in these hospitals, and although all aspects of life there are strictly regulated, it gives an impression of another world guided by different rules than the one beyond its walls. As Vybíral noted the ambivalence of protection and isolation that these secluded places represented at its conception remains a lasting characteristics of the hospitals. The invisible thread of curability that separates those who come here only temporarily and return to their world after they get better and those whose condition is incurable and remain here for years and decades and eventually die here is yet another interesting aspect of the order that finds its materialisation in these hospitals, and might be well understood through the concept of liminality.

In *The Ritual Process*, Victor Turner elaborates the concept of liminality introduced by Arnold van Gennep for description of *rites de passage*. The three stages – separation or detachment, the transition state, and reincorporation – are associated with different social characteristics of people who undergo the rite. The liminal condition represents moment ‘in and out of time’, and liminal situations are regarded as dangerous, inauspicious, and even polluting states of in between. Turner notes that the attributes of liminality are necessarily ambiguous:

“Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial. ... Liminality is frequently linked to death, to being in the womb, to invisibility, to darkness, to bisexuality, to the wilderness, and to an eclipse of the sun or moon. Liminal entities may be represented as possessing nothing. They might be disguised as monsters, wear only a strip of clothing, or even go naked, to demonstrate that as liminal beings they have no status, property, insignia, secular clothing indicating rank or role, position in a kinship system – in short, nothing that may distinguish them from their fellow neophytes or initiands. Their behaviour is normally passive or humble; they must obey their instructors implicitly, and accept arbitrary punishment without complaint.” (Turner 2008, p. 95)

Seeing some of the patients in the Kosmonosy hospital I was inevitably reminded of this description. Naked, without possessions, dependent on others to provide for them, yet often considered unpleasant and threatening, in a state more animal- than human-like. There is an ambiguity surrounding a patient as one who is perceived as a potential threat and at the same time as vulnerable and in need of protection. The spatial seclusion of patients in the hospital where they are accommodated to individual wards according to various classification corresponding to their status is not unlike the transition state of rites of passage. It might be a temporary seclusion from the outside world to which they return once they recover. However, in the cases where their condition is more permanent, they are transformed by their illness and occupy this liminal space indefinitely. The erasure of all social distinctions that occurs in these hospitals by becoming a 'patient' is very similar to stripping of the previous attributes of their personhood – all their other identities are suspended or even discarded. The patient becomes 'a case', 'a condition', and his personality becomes a background on which the illness is detectable and identifiable.

The distinctions of 'curable' and 'incurable' conditions also seem to correlate very closely with the amount and severity of stigma attached to people suffering from mental illness. Stigma is a Greek term that originally designated a mark on the skin made by burning iron and originally referred to the slaves working in mines.<sup>140</sup> This word is now commonly used as a sign of disgrace and infamy. People suffering from various illnesses and especially those that are threatening, contagious and therefore dangerous, are as a result often excluded from the community – and in extreme case of World War II also exterminated. The Kosmonosy hospital is an example of a place where patients suffering from severe and often incurable psychiatric conditions concentrate, and in many cases their conditions intersect with other stigmatized conditions: patients with severe forms of mental disability, patients with sexual 'deviance', patients with criminal history, and patients with dementia who are slowly disappearing from this world. The closeness of death, the non-human features, the states that frighten and threaten and endanger the integrity of individuals

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<sup>140</sup> In medieval times the word was used for the signs on the bodies of saints that represented the wounds of Christ after the crucifixion.

and communities. These are also conditions that in many other (pre- or non (post)-Enlightenment) cultural contexts are considered polluting. From this observation it is possible to conclude that there is a close correlation between the current concept of stigma to the more ancient ones of impurity and pollution. The categories of purity and pollution are not used anymore in our culture but they are often only covered by layers of other categories of more subtle meanings like medical diagnoses or other social categories (Douglas 2002). There are no rituals of purification other than healing in our society and if treatment does not provide the cure, then the state is permanent – until the death. The observation of the psychiatrist who described his hospital ward as a purgatory is a rather insightful metaphor in this context. The illness, as well as the actual location of the hospital represents a very specific form of liminal state, the space of in-between and of suspended time.

The containment or seclusion of patients in the hospital provides not only protection and but also isolation from the outer world. The patients share the conditions of inferiority, social marginalisation and exclusion. However, there is also this essential human bond created by a common fate, as Turner formulates it, and this unusual community of people sharing the same space – although not necessarily a harmonious one. The disappearance of the bonds with their original families and social surrounding often leaves the patients in a rather curious kinship with other patients who just by the sheer play of circumstances share their lives with them. The lack of privacy and the minimalism of life reduced to its very core components in the rhythm of the institution does make them into subject of the order imposed from the outside. Also, the indeterminacy of time for which they are secluded and their unclear prospects for the future makes their condition indefinite. The redemption comes in the form of healing – or in the form of death.

The closeness of death in this hospital was not only tangible in the actual moments when the names were deleted from the computer systems, clothes sent for disinfection, papers returned to the central office, but permeated the bodies of patients and radiated from the walls – *‘the way death has of announcing itself in*

*suffering*' (Levinas 1987, p 70). The disintegration, the pain, the loneliness, the life stripped of all its adornments, raw and unvarnished.

The seclusion of the patients nevertheless often extends even beyond death. In the Kosmonosy hospital there was no cemetery in the hospital premises – as was the case with Bohnice and other purpose-built hospitals with large cemeteries attached to them – and therefore the hospital was allocated a space in the village cemetery on the other side of the hill. This cemetery is divided by walls in three parts and the third one – on a remote end of the cemetery – was devoted to the hospital. There are no names or ornaments as on the other graves, just numbers, and this part is overgrown by high grass. This is where the deceased from the hospitals were buried as an obligation of the town in cases where no relatives were identifiable or none of their relatives was willing to bury them.<sup>141</sup> The exemption to this rule was represented by the deceased of Jewish origin were taken care of by their community: in 1901 the Jewish community addressed the hospital director with a letter asking exemption for postmortems for its members that were a commonplace in that time as this practice was incompatible with the Jewish religious law. They also asked for using plain wooden coffins without any ornaments or paintings as the death does not discriminate between rich and poor.

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<sup>141</sup> Those 'unclaimed bodies' were however also available to be used for the purposes of medical research and teaching.





Village cemetery, part devoted to the Psychiatric hospital, Kosmonosy 2007

The ethnic origin of patients was of crucial importance in the first half of twentieth century, where some of the attitudes towards patients suffering from mental illness took its extreme form. In Bohemia, Jewish and German population represented a significant proportion of citizens: German speaking population represented a third of the population in between the wars. The introduction of racial laws in Germany and their takeover of the neighbouring countries in the late 1930s represented a radical shift in treatment of mentally ill patients. In 1938 the borderline territory of Bohemia and Moravia – known as Sudeten – was annexed to Germany and the rest of the country was proclaimed a German protectorate, the public offices were committed to Germany, and hospitals were taken over by German directorates. In the hospitals under German directorate sterilization of patients was practiced and in some cases organised transports to concentration camps took place. This affected patients of both German and Jewish origin: patients of non-Czech origins from mental hospitals situated in Sudeten were transferred to Germany and subject to the

T4 program aimed to exterminate the ‘Lebensunwertes Leben’ – life unworthy of living.<sup>142</sup> This was targeted on physically and mentally handicapped people living mostly in the institutions (Lajkep 2006; Příkryl et Skula 1998). Kosmonosy was part of the area under German protectorate and only the patients of Czech origin were spared this fate. The overcrowded Dobřany hospital, also in Sudeten, was affected by the bombing of nearby industrial town Plzeň, and many of the patients found their death in the ruins. Those who survived were transferred to the nearby prison in Bory or elsewhere in the Reich (Klik 1988).

Even the remaining patients in Kosmonosy suffered significantly throughout the harsh conditions of war. The rations of food for patients were very low and at the typhus epidemics broke up. The hospital was directed by a German physician whose political convictions dictated a definitive solution and since it was not possible to do this in a straightforward manner, he found different ways to achieve this end. According to one of the doctors working there in that time, Dr. Oldřich Vinař who later become professor of neuropharmacology, the director cooperated on extermination by inoculating the patients by Koch bacilli – the death from tuberculosis was predictable and conveniently ordinary result. The protocols with detailed informations on this programme were later found in his laboratory (Mistorel 2006). Since most of the documentation from this period in the psychiatric hospitals was carefully discarded, the testimony of former staff is often the only historical resource there is. Moreover, the patients were rarely transported directly to their final destination there is a very little evidence of the fate of individual patients on which to draw thorough analysis of this phenomenon.

The sheer and unquestioned violence against the psychiatric patients nevertheless calls for some compelling explanation. Writing in mid-1980s Czechoslovakia, two Czech psychiatrists commented on these practices:

“The economic reasons in terms of which the whole T4 action was rationalized in the narrow circle of insiders were certainly not the real reasons. This paradox might be

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<sup>142</sup> The T4 program was hastily conducted between 1939-1941, with around 70 000 victims among psychiatric patients from different institutions. For the most comprehensive history of the euthanasia program for psychiatric patients on whose the methods for the ‘final solution’ of the ‘Jewish question’ were developed see Michael Burleigh, *Death and Deliverance: Euthanasia in Germany 1900-1945*.

explained by the anxiety of Germans caused by the threat of the inferior citizens of the Reich, or by some kind of mystical sacrifice of the mentally ill who live quietly in their institutions while the best sons of their nations are dying on the front.” (Příkryl et Skula 1988, p.73-74)

I will return to this motive of sacrifice in the final chapter.

The history of these hospitals thus embodies the history of this part of Europe in its most extreme: the turbulence of twentieth century has not avoided these places.



## Chapter 5: The Intellectual Context of Czech Psychiatry

### The Materialist Tradition



Bohnice hospital, aerial view, early 1990s (archive)

Bohnice hospital is now surrounded by a large suburb of high rise panel houses from 1970s that were built to accommodate the growing population of Prague and as a sign of Czechoslovakian-Polish friendship (most of the streets and buildings bear Polish names). This rather cramped settlement of plain concrete buildings is an unusual contrast to the spacious, beautiful and green hospital complex. It is a five minute walk from the nearest bus stop, and entering the hospital one has to find a small gate in the railing, pass through the administrative building and then the large park opens up.

In 1961 two buildings of the Bohnice hospital were set apart for the Psychiatric Research Institute westwards from the central line, next to the church and

the laundry. This was a response to the growing need of research in both biological causes and social consequences of mental disorder. In accordance with the policy of socialist state to monitor and improve needs of population in the area of mental health, psychiatry was identified as a priority of the five year plan in the late 1950s. The chosen location allowed for close cooperation with the largest psychiatric hospital as well as postgraduate institute for training in psychiatry located there since 1955. The historian of medicine, Michal Černoušek, commented on the location and setting of this institution:

“In the pleasant park environment that today represents the oasis of calm in the modern city, the researchers have very suitable ecological conditions for their work. Not only the treatment of disease requires calm and pleasant environment, but also the contemplation on how to treat and prevent the disease flourishes more in the appropriately chosen environment.” (Černoušek 1988)



Prague Psychiatric Centre, Bohnice hospital, 2007

The place where knowledge that would shed light on the obscurities of mental illness is gained and disseminated was thus posited in the very centre of the space where mental illness concentrates.<sup>143</sup> The basic assumption of biomedical research that the elucidation of causes and courses of illness would mitigate their implications and prevent them from occurring might be well understood as the continuation of the project of Enlightenment: the light of Reason conquering the darkening landscape of Madness.

This institution was unique as it combined research in neurobiology, biochemistry, ethology, psychology, psychopharmacology, electrophysiology, epidemiology and social psychiatry as well as other fields. The research focus was not only on the underlying causes and progress of illness and new forms of treatment but the emphasis was on prevention – in line with the orientation of socialist medicine. Apart from laboratory space the hospital also had three clinical wards of 100 beds in total (separate wards specialized in treatment of psychosis and psychopharmacology, social psychiatry, and psychogenic disorders). The research interests were rather diverse: from the measurement of catecholamines and their metabolites in the urine, the distribution of mental disorders in urban areas, the investigation of new psychotropic drugs. The unique studies of sensory and sleep deprivation, as well as longitudinal study of children born from unwanted pregnancies that runs now for more than fifty years are among the classical studies through which the work of the department became known in the Western countries. Even nowadays most prominent researchers and clinicians spend certain period of their training in this institution and they also author textbooks and research reports that have shaped the orientation of Czech Psychiatry ever since. Currently, the Prague Psychiatric Centre is a teaching institution for the Third Faculty of Medicine of the Charles University in Prague and the largest research centre in the country. The strong tradition of neuropsychiatry that dominated medicine in this geographical region for the past two centuries is cultivated here, and the auditorium is decorated

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<sup>143</sup> The metaphor of spreading the light in darkness by knowledge that elucidates the complexities of mental illness is also used in the patient education leaflet authored by researchers working here.

by portraits of famous psychiatrists – Karl Kuffner, Antonín Heveroch, Zdeněk Mysliveček, Vladimír Vondráček, and others.

The most prominent figure of the early twentieth century psychiatry was Karel Kuffner, director of the Neuropsychiatry clinic (1895-1929) and Professor of Psychiatry at Prague university. He studied in Vienna with Theodor Meynert, a famous neuropathologist under whose supervision he completed a work on the pathophysiology of psychosis published as *Pathological Anatomy of the Psyche* in 1891, grounding psychiatry firmly in the materialistic tradition. It is noteworthy that Vienna was the cradle of sciences of ‘psyche’ that nevertheless developed in various distinct directions. Another students of Theodor Meynert, Sigmund Freud, established psychoanalysis which in contrast represented the idealistic philosophical tradition (Tauber 2010). Freud conceptualized mental illness as a psychological process and developed rather complex ‘topography’ of the psyche understood in terms of the energy of life, whereas the neuropathology followed strictly the materialistic philosophical position and searched for the organic, biological substrate for psychiatric illness. This distinction had also significant implication for understanding the aims and means of therapy, and Karl Kuffner commented on this: “The philosophical spirit of the fin-de-siècle dictated its beliefs to psychiatry, too. The physicians approached mental illness from the purely psychological perspective, which is non-scientific in the natural science tradition and this impacted their attempts for therapy. They saw in madness as deviation of the spirit (i.e. mind) from the right logical paths and believed that unreason has to be treated by reason. They elaborated detailed and supposedly rational methods for the treatment of individual prevailing symptoms. It was necessary to gather thousands of experiences as an evidence that the essence of delusions has organic cause and therefore cannot be destroyed by psychological means.” (Kuffner 1897)

The historical and geographical trajectories of these two approaches to mental illness are rather interesting – while the tradition of psychoanalysis exercised significant influence on psychiatry in Western Europe and Americas, in Central and Eastern Europe it was the materialist approach that exerted influence all the way through the twentieth century – not least because this resonated well with the Marxist philosophy that influenced the ideology of the Soviet era.

In 1897-1900 Kuffner published the first authoritative textbook of psychiatry in Czech and this book became the source of neuropsychiatric knowledge for the first half of the twentieth century. He positions his approach to mental illness authoritatively in the tradition of neuropsychiatry:

“It is very likely that psychosis correlates with a minute material disruptions which nevertheless are so minute that with our current methods these are not detectable. The psychosis is considered as a deviation of the functions of the psyche which can be proved to be a result of incorrect development or illness of the central nervous system. Our hypothesis is that the anatomical substrate of even the simplest act of imaginations are located in various cortical centers.” (Kuffner 1897)

The insistence on the organic – biological – basis of psychiatric illness was something shared with the older German tradition represented by his contemporary Emil Kraepelin. In contrast to Kraepelin’s nosological approach to diseases Kuffner emphasized the importance of the etiology of symptoms as an underlying principle of the classification of mental illness (Šedivec 1988). As a director of the Psychiatric Clinic, Karl Kuffner established laboratories for biochemistry, histology, and liquorology to study the organic basis of mental illness. In line with the positivist philosophy of his time he was very empirically oriented and encouraged his students to study the correlation of findings in physical examination of their patients with the laboratory results. The project of one of his collaborators, Jan Janský, was to examine blood as a potential origin or at least an indicator of mental illness.<sup>144</sup> This research was published in 1907 publication of a study entitled *Hematological Study of Psychotics* in which he examined 3160 cross-agglutinations from blood samples of psychotic patients and compared them to that of healthy subjects. Although he identified four blood groups – an important discovery facilitating blood transfusion – he did not find any correlation between the blood characteristics and existing mental illness: “*Our systematic examination did not bring any valuable practical benefit, although it revealed remarkable, not yet described data.*”<sup>145</sup> Janský continued with

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<sup>144</sup> This motive – mental illness ‘reflected’ in blood – is certainly worthy of further research, given the role of blood in the cultural and medical imagination of that time, especially in relation to eugenics.

<sup>145</sup> Jan Janský never followed this direction and it was Karl Landsteiner (who identified three of the four groups in 1900) who is now credited with the discovery of blood groups that facilitated blood transfusion which especially during the war saved many lives.

his research on the characteristics of blood and spinal fluid in psychotic patients and later became director of the Neuropsychiatry Clinic in Prague.<sup>146</sup>

In 1919, the ‘Purkyně Society for the Study of the Soul and Nerves’ was established (later renamed as Czechoslovakian Psychiatric Society). This Society was named after Jan Evangelista Purkyně (1787-1869) a professor of physiology at Prague and later in Wrocław University who founded the first laboratory of physiology and gained a worldwide fame for his morphological and physiological studies of sensory and nervous system.<sup>147</sup> He shared the same positivist and materialist approach to mental processes as his contemporary, Jan Theobald Held, professor of medicine and director of the Prague psychiatric clinic who wrote in 1812 “*thinking is a certain kind of chemical process*”. It was this paradigm in which the research in physiology and neuropsychiatry flourished over the next two centuries.<sup>148</sup> The association and correlation of the concepts of ‘Soul’ and ‘Nerves’ became engrained in the neuropsychiatric school, and the search for organic causes and treatment was later supplemented by psychopharmacological studies – Vladimír Vondráček’s authoritative *Pharmacology of the Mind* was published in 1935. The research in medicine, neurology and psychiatry was thus dominated by the search for organic causes of mental illness understood in terms of defective development of the central nervous system, anatomical lesions or degenerative disease of the brain. It was only in 1955 was the Purkyně Society divided into Neurological and Psychiatric Societies and the neurology and psychiatry were constituted as independent areas. This division was retrospectively interpreted by psychiatrists as an attempt to protect neurological patients from the stigma of psychiatry (Libiger 2002).

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<sup>146</sup> The search for characteristics in blood was nevertheless not mistaken: in 1905 the causative agent of Syphilis, *Treponema pallidum*, was identified by Erich Hoffmann and Fritz Schaudinn in 1910 Salvarsan was synthesized by Paul Ehrlich. This treatment had significant impact on psychiatry since at that time large proportions of patients suffered the late stages of neurosyphilis. This case was also often used as an argument for the organic cause of mental illness.

<sup>147</sup> Purkinje cells in the cerebellum and heart bear the name of this scientist. In addition to his work on physiology and pharmacology – he described experimental effects of belladonna, camphor and opium on humans, and tested digitalis toxicity on himself – he was also a great representative of the humanistic tradition of his time.

<sup>148</sup> The notion of ‘mental illness’ in Czech has significantly less emphasis on ‘mind’ than its English form. The Czech term is ‘duševní nemoc’ – the illness of the soul – in Czech or *Geisteskrankheit* in German – the illness of the spirit. More discussion in Chapter 5.

After World War II, the emphasis on evidence and rationality taken from the positivist philosophy and adapted by the prevailing Marxist materialistic philosophy was strongly institutionalized in medical education: all university students had to attend classes of ‘Marxist-Leninist Philosophy’ and ‘Scientific Atheism’.<sup>149</sup> This ideology was aimed to permeate the consciousness of the students who were supposed to disregard those ideas about the nature of human life that came from idealistic philosophy or religious teaching then discarded as unscientific. Professor of Anatomy, Lubomir Malinovský wrote in 1981 that anatomy not only provides the theoretical grounds for the study of medicine but also contributes to the formation and consolidation of scientific worldview. He furthers his argument for the importance of neuroanatomy for understanding the essence of human nature:

“Nowhere else is the conclusion of Marx that *‘thinking is a product of matter at the highest stage of development’* and that the *‘brain is thinking matter’*. The vertical organisation of central nervous system demonstrates the functional hierarchy of its individual layers derived from the phylogenetic stage of development. The most recent and most differentiated part of central nervous system – the cortex – is an organ of consciousness and thinking that exists inseparably from the living matter.” (Malinovský 1981)

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<sup>149</sup> These subjects were obligatory and the textbooks are very revealing, see for example *Základy marxisticko leninistické filosofie* [Elementary foundations of Marxist-Leninist Philosophy], Nakladatelství Svoboda 1975, and *Vědecký ateismus* [Scientific Atheism], Nakladatelství Svoboda 1977. Both of these textbooks are translation from Russian.



## The Organism and Its Environment

Although attracting a critique for reducing the richness of human life to its biological substrate, this neuropsychiatric approach is not necessarily contradictory to the more holistic understanding of integrity of human organism and the social context of life. Jan Evangelista Purkyně wrote in 1823:

“The task of the physician is not only to restore life and prolong it for a short time, but also to protect it from corruption and help it to attain the summit of admirable perfection and beauty. Attention is not yet paid to the fact that medicine will not be perfect in all its aspects until – as far this is at all possible in face of such great changeability and hostility of external forces – it starts teaching how to invigorate the fragile human organism, how to prevent affection and combat illness, and until it is capable of performing these tasks in such a way as to enable human life that was well conceived to pass through all its phases, properly adapting itself both to the limits of the individual and of the society, and to be happily and gloriously perfected to its natural end.” (in Prokůpek et al. 1968)

The goal of medicine is to restore the integrity and adaptability of the organism where the external environment is as crucial as the internal factors in both health and illness. The notion of the ‘therapeutic environment’ has a strong tradition in this region: the beautiful and peaceful parks in which hospitals were located as well as the emphasis on safe and stimulating environment inside are materialized the architecture of these spaces. However, it is not only the physical but especially the social environment that is of decisive importance for the recovery of the patients. Purkyně’s contemporary, Professor Jan Theobald Held, the director of the Psychiatric clinic in the early 1900s was also influenced by the methods of Philippe Pinel who in a similar manner emphasized the role of humane, kind and supportive environment – known as *traitement moral*. The therapeutic approach to mental illness that consisted of treatment on the level of both the physical – biological – processes as well adjustments in the social environment thus represents the merging of the ‘biological’ and ‘humanistic’ tradition in medicine. Additionally, in accordance with the understanding of that time of the therapeutic importance of water there were several



large spa complexes established in different parts of the country for patients suffering from psychiatric ailments who received mineral water treatments there.<sup>150</sup>

The stream of thought that emphasized the importance of the environment on the life and health of the organism also found its continuation in the twentieth century. In addition to the materialistic neurobiology it was also the evolutionary theory that was appropriated and reinterpreted by the Marxist philosophy. These were incorporated into the official ideology promoted by the communist regime.

The works of Charles Darwin have been eagerly embraced by the theorists as an explanation of human nature as an alternative to the repudiated religious worldview. The evolutionary biology was often intertwined with human ethology in order to explain human behaviour in terms of adaptive interactions with the environment, and this approach significantly influenced the understanding of mental illness in psychiatry. As part of the experimental psychiatry in the 1960s the Psychiatric research institute established a laboratory of neuropsychopathology lead by psychologist Jaroslav Madlafousek and zoologist and biological anthropologist Zdeněk Klein.<sup>151</sup> On animal models – mostly rats – they studied behaviour, communication and the adaptation to changing external – social – conditions. Their main interest was the role of ‘social relationships’ on the behaviour of the individual (Klein 2000). Mental illness in this context is understood as a specific adaptation – or maladaptation – to external conditions. The mediating factor for the behaviour of the individual is the central nervous system: *“In the perspective of evolutionary psychology the brain contains specific mechanisms that natural selection shaped to generate adaptive patterns of behaviour.”* (Höschl et al. 2002, p. 214)

Psychiatry thus describes abnormal behaviour as a response of the individual to the environment in which they live, a response that is influenced by various factors. As the textbook of psychiatry has it:

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<sup>150</sup> One of these spa, Jeseníky, is currently a location of the annual congresses of the Czech Psychiatric Society.

<sup>151</sup> Klein’s work was disrupted in early 1970s when for his activities in the dissent he became a political prisoner, worked later worked as an auxiliary in a factory and returned to research only in 1990

“There is no doubt about the interaction of different internal (genetical) and external (psychosocial and environmental in the wide sense) factors on the development of mental disorders. Mental disorder is a result of their influence on the regulatory mechanisms of the affected individual.” (Raboch et. Zvolský 2001. p. 18)

This evolutionary and ethological perspective was often emphasized in teaching of psychiatry to medical students to illustrate that the apparently pathological and incomprehensible behaviour can actually be considered as ‘logical’ and even meaningful response to external (mostly disturbing) factors. This approach challenges the more traditional understanding of mental illness where there can be clear line drawn between ‘normality’ and ‘pathology’. Rather, by seeing the illness as a process, as a response to specific external conditions, it makes the illness intelligible.<sup>152</sup> In one of the seminars I attended Dr. Filip Španiel explains this to students using the example of depression:

“People are most fearful in situations over which they have no control. Such chronically unresolvable and overwhelming situation can be a cause of depression with clear neurobiological correlates. The best way to experimentally induce depression in animal models is to put them into a cage from which there is no escape, and give painful stimuli to their limbs. Earlier or later the animal gives up, withdraws to a corner, ceases to consume water and food and ceases to move. The humans are the same. When someone – especially someone suffering from mental illness – is living in the society that does not care and is completely indifferent towards them and the only thing you can offer to them is life in the overcrowded psychiatric hospitals you can very easily make them feel entirely helpless and hopeless. Something has to be done about this.”<sup>153</sup>

This perspective on mental illness thus takes seriously both biological and social influences on the development of mental illness. Dr. Jan Libiger, a professor of psychiatry, explains:

“Most psychiatrists consider mental illness to be primarily a disease of the brain, while there are some others who consider it an illness of human relationships. These

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<sup>152</sup> This approach was developed in parallel also in the tradition of German phenomenological psychiatry of Karl Jaspers, existential psychology of Ludwig Binswanger, and neuropsychology and Gestalt psychology of Kurt Goldstein that also influenced the work of Georges Canguilhem. Although this tradition had no influence on official psychiatry in the Czechoslovakia these perspectives permeated here through phenomenological philosophy that significantly influenced the Charter 77 movement and evoked interest in psychotherapy. Only after 1990s this area was being systematically studied – Petr Kouba’s book *The Phenomenon of Mental Disorder*.

<sup>153</sup> Dr. Filip Španiel, seminar for students, 2007

two are overlapping. If the brain does not work well the relationships are seriously affected by that. Disturbed human relationships can lead to dysfunction of the systems and processes in the brain. The brain responds to events around us, to the social environment and to the psychological influences by changes on the level of molecular expression, on the level of neurochemical and neurophysiological processes as well as on the level of morphology. The distinction between psychological processes and brain functions is therefore rather illusionary.”<sup>154</sup>

The biological and psychosocial approaches to mental illness – often considered contradictory – actually complement each other in this perspective. The attribution of mental illness to biological causes relieves the patient of guilt and stigma that too often accompany the diagnosis. On the other hand, the emphasis on the role of the environment in terms of its therapeutic potential makes possible interventions that complement the medical treatment of the conditions. Dr. Jan Libiger touches upon this when he explains the nature of mental illness:

“Many people still more or less consciously understand psychiatric illness as a weakness, something not unlike a sin, a moral failure or their consequences. But in fact the vast majority of mental illness is a multifactorial disorder with verifiable hereditary components. Mental illness can be understood analogous to systemic autoimmune disorders as disorders of adaptive processes. In the same way as the highly effective protective immune mechanisms can go awry from the adaptive roles for which they were selected by natural selection, depression and anxiety can get out of control. Anxiety is a very powerful instrument of socialization. It protects active individuals and their initiative and courage from death and extinction to which they would be exposed if they were not protected by anxiety that prevents too risky behaviour. In the same way depression that leads to the loss of initiative and joy from various activities protects humans from the loss of important values or allies from initiatives that might lead to failure and would have catastrophic consequences for their evolutionary fitness. The variability of this naturally adaptive mechanisms then causes that some of their extreme forms or the excessive and overwhelming stresses lead to dysfunction and disorder. Evolutionary medicine can thus explain phenomena as schizophrenic symptomatology, self-reference, autism and other psychopathological phenomena in the context of their originally adaptive function.” (Libiger 2002, p. 14)

Psychiatrists sharing this view also tend to emphasize that there is an evolutionary benefit in traits that in their extreme form make the individual prone to mental illness. They often give examples of very creative, unusually gifted and

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<sup>154</sup> Interview with Jan Libiger in ZDN, 14.6.2011 <http://www.zdn.cz/rozhovory/predstavujeme/445794>

intelligent people, who suffered from mental illness, or traits that tend to run in families that make some of the members extraordinarily successful and others, whose nervous system is prone to instability, subject to mental illness. Dr. Filip Španiel, conveying this perspective to medical students, uses these words: *“psychiatric illness is the forfeit for the most complex hardware we keep in our heads, the most awesomely complex universe in the universe which we call human brain.”*

Another representative of the biological tradition whose work became influential in this region was I.P. Pavlov, a Russian physiologist working around the turn of the century<sup>155</sup> Although his research was originally in the physiology of digestion his most influential work on reflexes and their role in conditioning extended to the more complex area of interactions between organism and its external environment. In the 1903 paper, *The Experimental Psychology and Psychopathology of Animals*, he presents reflexes as an elementary phenomena of both physiological and psychological nature. These two realms – psychological and physiological – therefore coincide and their neurological basis can be examined empirically and can also explain the functioning of the organism and its responses to the environment. He identified the cerebral cortex as the ‘prime distributor and organizer of all activity of the organism’ and was aiming to identify the laws governing its behaviour. His later experiments on conditional reflexes led him to simplified mechanistic and rather deterministic approach to the organism. However, in an essay on the conditioned reflex he also maintains that *“the animal organism, as a system, exists in surrounding nature thanks only to the continuous equilibrium of this system with the environment, i.e., thanks to definite reactions of the living system to stimulations reaching it from without.”* (Pavlov 2001) This dialectical approach therefore maintains some of the holistic perspective on the relationship of organism and its environment.

Pavlov’s ‘artificial conditioning’ theory was eagerly embraced by the proponents of Marxist-Leninist ideology as it allowed for social engineering approaches that characterized many state policies in the Soviet era, exerting its

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<sup>155</sup> [http://www.nobelprize.org/nobel\\_prizes/medicine/laureates/1904/pavlov-bio.html](http://www.nobelprize.org/nobel_prizes/medicine/laureates/1904/pavlov-bio.html)

influence over Eastern and Central Europe (Moore 2013). However, this theory also significantly influenced some of the more pedagogical approaches to the treatment of mental illness with an emphasis on conditioning, learning, reinforcement and behavioural change. In the 1960s this pedagogical approach has been elaborated in more sophisticated ways as the theories of cybernetics found its way to psychiatry, in Czechoslovakia especially through the work of Vladimír Vondráček. Pavlovian inspiration eventually made its way back to psychiatry worldwide as behavioral and later cognitive-behavioral psychotherapy (CBT).<sup>156</sup>

The influence of the Pavlovian theories is evident in the book *Psychiatry in the Communist World*, edited by New-York based psychiatrist Ari Kiev in 1968. The authors Josef Prokůpek, Jaroslav Stuchlík and Stanislav Grof confidently posit Czechoslovakian psychiatry in the materialistic and positivist tradition.<sup>157</sup>

“Czech psychiatry still basically maintains the materialistic conception which ensures that it shall retain its scientific foundation and will not slip into doubtful theories and practices that only formally resemble the scientific approach. Fifteen years ago our psychiatry had an occasion to become more deeply oriented toward the neurophysiological doctrine of I. P. Pavlov, which supplied not only the reflex principle of psychic activities but also the concepts of formative influence of outer environment, the integrity of the individual, and the milieu. This has played an important role in the problems of the etiopathogenesis of psychic disturbances as well as in the introduction of new forms of psychiatric care and new principles of mental health care of the whole population.” (Prokůpek et al. 1968, p. 128)

The authors address current state of research into biological factors in mental illness, especially schizophrenia, on genetic factors in psychic disorders, and the study of psychotropic drugs – all of which was informed by the neurobiological

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<sup>156</sup> The influence of Pavlov’s theories is also evident in the more ‘Western’ behaviourist psychology of John B. Watson, Edward Thorndike and B.F. Skinner. There is yet another similar motive shared by both western and eastern approaches in terms of the ‘improvement of the society’ – B.F. Skinner’s 1971 book *Beyond Freedom and Dignity* is actually not that far from the theorists of the socialist utopia of social engineering – Pavlov’s theories also served as an inspiration for Aldous Huxley’s 1931 dystopia *Brave New World*.

<sup>157</sup> Jaroslav Stuchlík was a student of Kraepelin and Bleuler who also introduced psychoanalysis to Czechoslovakia; Josef Prokůpek also came from the old German tradition and in 1950s established the Postgraduate Training institute in Psychiatry; Stanislav Grof came from the young generation of psychiatrist leading the research in the psychedelics (LSD especially) and altered states of consciousness – he emigrated in 1967 to the USA where he established the school of transpersonal psychology and ‘holotropic breathwork’.

orientation of psychiatry.<sup>158</sup> The earlier distinction between ‘soul’ and ‘nerves’ thus almost entirely collapsed into one single concept of the central nervous system. The biological orientation of psychiatry, the emphasis on the integrity of the organism and the role of its environment thus directly informs the forms of therapy as well as the organisation and practices in psychiatric care. In addition to pharmacotherapy, electroconvulsive therapy was often used in that time, in some cases also insulin shock therapy, hydrotherapy, and pyrotherapy – all of these firmly entrenched in the biological understanding of mental illness.

However, this approach also served as a grounding for work therapy, art therapy and resocialisation that were considered important instruments of psychiatric treatment. The emphasis on work was reflected in the social rehabilitation approach through work therapy in psychiatry:

“In Marxist theory work is viewed as man’s most important activity. It is felt that man’s consciousness grows and his relations with other men develop within the framework of economic activities. According to the Soviet Constitution, work is a duty and matter of honor.” (Kiev 1968, p. 17)

This emphasis on the role of work also has other intellectual roots: K. Marx and G. Engels in their work *The Role of Work in the Humanization of the Ape* claimed that the decisive condition for the transition to human was work. The work thus serves also rehabilitation and reestablishment of human nature.

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<sup>158</sup> Among the original psychotropic drugs developed in Czechoslovakia is Dosulepin (Prothiaden), highly effective antipsychotic drugs Clorotepin, Oxyprothepin and Isofloxythepin. David Healy notes that during 1950s and 1960s Czechoslovakia produced more new drugs per capita than any other country (David Healy. 2012, p. 18).





Heaps of leaves collected by patients as part of work therapy, Kosmonosy hospital, 2007

Kiev's chapter on Czechoslovakian psychiatry list different therapies that were used at that time: ergotherapy and work therapy, collective psychotherapy,

psychodrama, psychogymnastics, musicotherapy, bibliotherapy, art therapy, hydrotherapy and physiotherapy, and hypnotherapy – most of them exercising the therapeutic influence through the environment, causing changes in the nervous system. In the introduction to the book Kiev defines psychotherapy in terms that at that time used very different vocabulary than the most prominent psychotherapeutic school of the West, psychoanalysis:

“Psychotherapy is thus viewed as a process of reeducating the central nervous system by extinguishing pathologically conditioned connections and forming healthy new ones. Healthy mental processes are considered the result of a harmonious equilibrium between inhibition and excitation and between the first and second signal systems. A disruption of the latter impairs the capacity for abstract thought and is expressed clinically in disorganized behaviour and thought. The therapeutic goal, then, is to inhibit pathological activity of the higher nervous centers and hence strengthen cortical control. To this end rest, relaxation, and suitably selected work are prescribed.” (Kiev 1968, p. 18)

Although there was some influence of psychoanalysis on Czechoslovakian psychiatry in the interwar, World War II significantly affected the psychiatric profession. Before the war a significant proportion of psychiatrists were ‘either Jews, or communist – often both’ (Vinař 2006). The lives of those who did not manage to emigrate early enough were discarded in the concentration camps – among them Leo Taussig, Professor of Psychology and Neurology at Prague University. These were also the psychiatrists who had been influenced by the ideas of Sigmund Freud and his followers. Only a handful of psychiatrists remained in their profession after the War and after the ‘Society for the Study of Psychoanalysis’ was dissolved in 1950 psychoanalysis was practiced unofficially.<sup>159</sup>

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<sup>159</sup> Although since the early years of WWII psychiatry suffered significant isolation, the ‘older school’ of psychiatrists still benefited from their previous contacts with Austrian, German and French psychiatry (in the latter case it is noteworthy the collaboration with the initiative of the Ligue D’Hygiene Mentale de Paris). After the war the collaboration turned eastwards and was limited mostly to the countries of Soviet bloc – Poland, USSR and Yugoslavia among others – especially in the areas of neurobiological research, epidemiology and social psychiatry. However, in 1966 Prague also hosted the conference of the International Federation for Mental Health, in 1970 the congress of the Collegium Internationale Neuro-Psychopharmacologicum (established in 1957 in Zurich) and The Psychiatric Research Institute became a collaborative center of the WHO. Significant proportion of psychiatrists emigrated either in 1948 (after the communists took over the government) or 1968 (after the invasion of Soviet army) and many of them also kept informal contacts with their former colleagues to the extent the regime allowed them.



The revival of psychotherapy around 1968 and after 1989 – described in Part I – has never been in form of pure psychoanalytical teaching but consisted of rather eclectic approach inspired by various psychotherapeutic schools that were complementing the ‘official’ neurobiological orientation of psychiatry. The psychotherapist were both psychologists and psychiatrists by training and formed relatively small community of people who knew each other well and pursued a variety of directions in psychotherapy. Even the psychodynamic psychotherapy had much more emphasis on interpersonal dimension of human life than on the enigmatic psychological forces and the inner structure of the self. The authors of the 1968 book on psychiatry formulate it in the following terms:

“As far as psychotherapy is concerned, it is generally acknowledged that it represents an important and indispensable method, which should accompany any other therapeutic approach. It is widely used in its unspecific forms – encouragement, support, persuasion, suggestion, reeducation, consulting, rational explanation, etc. Psychoanalysis, even though historically it is closely linked to our country (Freud’s birthplace was Příbor in Moravia) has never achieved wide acceptance. Rational, dynamically oriented psychotherapy was not used on a broader scale until last decade, and this dynamic psychotherapy can be characterized – in contradiction to orthodox Freudian analysis – by an interpersonal orientation and great regard to social factors.” (Prokůpek et al. 1968, p. 140-141)

The range of therapies that emphasised the biological but also the interpersonal and environmental interventions were thus informed by the very specific understanding of the nature of mental illness. From this perspective, what is important is not only the biological makeup of the organism, but also their life situation and social environment. The therapy thus works also through adjustments in the external circumstances and social environment. This provides the link to the earlier discussed notion of the ‘therapeutic environment’ that informed the architecture of psychiatric hospitals, and in more recent times also the shift of care to the community. It also provides arguments for the need to change the attitudes of the public to become more welcoming to people suffering from mental illness and to overcome the stigma, an ethical imperative that inspired the initiatives for transformation of psychiatry.

## The Category of Mental Illness as an Explanation of Psychotic Experience

The meaning of the term ‘mental illness’ in Czech language carries different implications than in English. The word for ‘illness’ in Czech language – ‘nemoc’ – is a negation of the word ‘moc’ which means power, control, capability or agency.<sup>160</sup> The verb form of the same root, ‘moci’, means ‘can’ or ‘make possible’. The term thus literally translates as ‘no-power’, or even ‘impossibility’, and its close relative, the word ‘bezmoc’ means powerlessness. The term thus refers to an experience which is beyond one’s power or control, an experience of imposed limits that is in core of the illness experience. The word ‘nemoc’ is also the only word used to capture the notions of illness, disease and sickness in English. The classical distinctions between these terms as elaborated by George Engel, Arthur Kleinman and Byron Good for English does not work in Czech.<sup>161</sup> These terms which in English scholarly literature are commonly used to distinguish between subjective experience, objective symptomatology and a social role are all conjoined within a single term which refers to an existential condition of limited possibilities.

The word for mental illness is *duševní nemoc*, means literally the illness of the soul (rather than mind as in English).<sup>162</sup> The concept of the soul has disappeared from the medical discourse and its use is limited to poetic language and religious discourse. The denotation of mental illness as an affection of the soul is thus to be understood as an ancient cultural category that underwent significant semantic shift and became a ‘dead metaphor’ (Ricoeur 1975). Given the absence of the concept of

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<sup>160</sup> Although there is no Czech word to translate the concept of agency, this concept is often expressed through the grammatical distinction between the active and the passive voice. The category of illness allows for a shift from the active to the passive by interposing the illness as an agent on the place of the subject.

<sup>161</sup> The common distinction is of illness as subjective experience, disease as objective entity, sickness as a social role. George L. Engel. The Need for a New Medical Model: A Challenge for Biomedicine. Science, New Series, Vol. 196, No. 4286 (April 8, 1977), 129-136; Arthur Kleinmann. The Illness Narratives: Suffering, Healing, and the Human Condition. Basic Books 1989, 3-7; Byron J. Good. Medicine, Rationality, and Experience. An Anthropological Perspective. Cambridge University Press, 1994, 53, 117.

<sup>162</sup> This is not dissimilar to the German term *Geisteskrankheit*, or *Seelische krankheit*, affection of the soul or spirit.

the soul in the neurobiological discourse it is interesting to observe that the patients actually do recourse to this notion as we shall see later.

Unlike many other medical specialities where the disease is accessible to the perception through senses – often assisted by various technologies – making the illness visible and thus establishing it as evident is one of the key aspects of psychiatric practice. The illness in psychiatry is accessible through its symptoms of altered perception, experience or behaviour, which are much more resistant to objectification. Psychiatrists are thus dependent on the subjective account of the patients and their own observation of altered patterns of behaviour which they translate into the language of psychopathology. They are trained to see the illness behind the variable and temporarily unstable phenomena and narrated account of the patient's experience. They thus move from the unique to the universal, from the specific life situation of the patient to the abstract categories of psychiatry and neurobiology.

I will now examine the processes through which psychiatrists and their patients identify and describe psychotic symptoms, especially altered perception and distorted interpretation of reality, and how they explain them. On the example of schizophrenia I will follow the various ways of understanding the illness that are established, negotiated and transformed in the diagnostic and therapeutic dialogues. I will focus on three areas: first I will introduce the category of illness in the context of psychiatric practice, then I will address the question to what extent and for what reasons the patients adopt this category as an explanation of their own experience, how they alter its meaning in their life narratives and what alternative explanation of the origin and nature of their illness they provide if they do not find the medical explanation as satisfactory, and finally I will compare the differences of these various perspectives and their implication for the self-understanding of the patients.

Schizophrenia is a severe psychiatric illness that affects about 0.5% of the population. It is characterised by altered perception, cognition and emotive colouring of experience which result in altered behaviour and actions and consequently transform the life of the patients, their relationship to themselves as well as to others.

Their behaviour can be unusual, inadequate or bizarre and often distorts their social interactions. These transformations become noticeable to others and tend to constitute a reason for psychiatric examination and hospitalisation. Psychotic states are often referred to as the ‘loss of contact with reality’ and patients in the acute state are not able to discern that their perception is altered and their interpretation of reality is mistaken and therefore constitute a symptom of the illness (this is referred to as ‘anosognosia’ or ‘loss of insight’). These symptoms of illness correlate with specific alterations of the structure and function in the brain on the level of cellular metabolism and neuronal signalization. The illness has a significant hereditary component and the first signs usually appear in early adulthood or late adolescence, and the course of illness tends to be chronic: some patients have symptom free periods (remissions) in between individual acute states (attack/relapse); other patients have some of the symptoms permanently and they tend to worsen over time (chronic and residual form); and yet others may have only one such episode in their life. Psychiatry also makes the distinction between so called positive and negative symptoms – positive symptoms refer to the occurrence of normally absent phenomena such as hallucination, delusions, confused and bizarre behaviour; negative symptoms refer to the absence of normally present phenomena such as muffled emotions, lack of motivation and interest, indifference to social relationship. Psychopharmacological treatment is more successful in relieving of the positive symptoms while the negative symptoms are often resistant to treatment and tend to persist in the chronic form. Despite various literary tendencies to romanticize schizophrenia its effect on the life of the patients tends to be very destructive.

The first contact of patients with the psychiatrists usually occurs in the course of the acute psychotic state. The psychiatrists form the conclusion about the clinical state of the patients based on patient’s account and their own observations, and sometimes also on the accounts of patient’s relatives. It is important to acknowledge that both psychiatrists and patients enter into their interactions with certain pre-understanding influenced by their previous experiences as well as possible familiarity with the medical interpretation of psychotic experience. The

phenomenologist and psychiatrist Karl Jaspers observes that psychotic experience is incomprehensible in terms of common experience, and the psychiatrists are thus dependent on analogies (Jaspers 1968). They are limited in their possibilities to understand the experience from inside but by the virtue of the tradition of their discipline they are equipped with expert explanations of this experience.

Metaphorically speaking, the patients are traveling through a landscape to which the psychiatrists have no access to but they still do have the map of this landscape. Based on the patient's description they try to identify certain characteristics of the landscape and correlate them with their representation, and make a detailed representation of the landscape so that the map can provide orientation to both of them. This map, the knowledge about illness, is their collaborative creation which also becomes their guide.

In the acute state of psychosis the patients are often confused and unable to reflect on their own experience, and therefore even the communication with the psychiatrists is affected by this. The accounts of the patients tend to be fragmented and incoherent – which in the perspective of psychiatrists constitutes one of the symptoms of their illness. Since the specific accounts of patients in this phase are not very illuminating I shall introduce the retrospective account of this state by one of the patients:

“The very first attack came out of nowhere and I suddenly felt like something was flowing into my head, and I suddenly found myself somewhere else, like in a different world, and I ceased to apprehend my actual surroundings. It was like if the surroundings became black and white, and it felt completely hopeless, completely dark, without end, and I felt like it will only get worse and I just thought I cannot endure it any longer and I would rather end my life myself.”

The patient at this stage describes how she was experiencing the whole situation without recourse to expert categories. The motive of passivity – finding herself in a situation that is overwhelming, numbing, over which she has no control whatsoever and to which she can only respond somehow – is a motive that was present in the narratives of all the patients and is likely to be one of the key characteristics of psychotic experience (the notion of ‘nemoc’ in Czech has its experiential grounding).

In the following excerpt from an interview of a patient with a medical student, the patient, who has been hospitalised previously multiple times, uses psychopathological categories to formulate and describe her complaints, such as hearing of voices and phobias. However they are still intertwined with the life narrative in the common terms.

“May I ask first what problems you have, why are you here?”

“Voices, no other issues...”

“And what kind of voices these are, do you know them?”

“They are both male and female voices, They address me as well as just talk about me.”

“Where they giving you any advice as what you should do?”

“No, I do not think so...”

“And did you ever have any other problems?”

“Previously I had a phobia... The phobia was very present. I was with her all the time. I was entirely paralysed by her. I had problems with my husband and I thought I cannot bear all that anymore, but I still had to live through it. I was working two jobs at the same time, a day one and a night one. I exhausted myself, and it affected my health, and then also my father died and I could not bear it anymore, I just fell into pieces... I was entirely burned out from inside. I should not have done that. I was only drinking tea yet I still did not die then... I was paralysed physically and psychically too. I did not suffer from the voices, then, it was just all... very depressing...”

This short dialogue follows the structure typical of a psychiatric examination where the doctors target the alterations of experience and behaviour with their questions. Based on the patients’s accounts complemented by their own observations and possibly diagnostic tests, they structure the accounts using psychopathological categories: the altered experiences and behaviour become symptoms, the combinations of symptoms become syndromes referring to a specific nosological concept, i.e. a diagnosis. The diagnostic process thus represents a ‘translation’ of the narrative of the patients into categories of psychopathological nosology, based on strictly defined criteria. The first task of psychiatric practice is to learn how to ‘read the symptoms’ and ‘see the illness’, as the psychiatrists explains to his students.

“In the case of this woman it is a chronic paranoid schizophrenia. The delusions are long gone, only she still hears the voices. People are plotting against her through colour code. During the last hospitalization she was afraid to listen to the radio. You see this persistent delusional egocentric sensibility. It is a paranoia, psychotic in its

core. In the past there was a rich colourful psychotic symptomatic. What about the voices now? Were there more of those voices? What were they telling her – you need to make note of all this, describe these first rate symptoms which refract the diagnosis of psychosis and schizophrenia. Sometimes you can find two delusions intergrowing among each other.”

For the psychiatrist the voices are the hallucinations and the fears about being persecuted represent irrefutable delusions that force the patients to stay at home anxiously. The auditory hallucinations and delusions are unequivocal symptoms of psychosis, in this case schizophrenia.

In the medical perspective, every disease has its own characteristics which nevertheless can be quite variable and develop over time, as one of the psychiatrists explains to the students:

“Many of these conditions first appear as phenotypically unspecified. The other young man you saw a while ago was treated for eight years with social phobia, and now it is unambiguously confirmed as paranoid schizophrenia. It seemed quite straightforward, he did not want to leave home, was scared by people, was unable to eat out or just use public transport, like really severe form of social phobia, and now you see him with all this psychotic ideation – it is a full blown schizophrenia.”

Psychiatrists thus first abstract from the individual symptoms of the patient and describe their findings in the language of general psychopathological categories which describe the irregular characteristics as standard symptoms of the disease which has its specific place in the psychiatric classification scheme. The specific diagnosis is thus an epistemological construct: the alterations of perception, experience and behaviour are in accordance with diagnostic criteria abstracted and objectified into a specific disease entity.

These diagnostic procedures are analogical to the algorithms of somatic medicine where the disease has specific biological correlates on which the diagnostic process is focused, and consequently become the target for the treatment. Although the disease in psychiatry is not directly accessible to the sensory perception (today mostly assisted through various technologies) as in most other medical specialties, making the disease visible is one of the aims of psychiatric research. As an illustration of this ideal might serve the following excerpt from the psychiatry textbook:

“The development of imaging methods in recent years enabled psychiatrists literally to see even those parts of brain that are the substratum of mental illness. Knowledge of neuroanatomy is essential requirement for perfect understanding of the essence of most psychiatric illness. Understanding the neuromediator equipment of the relevant structures contributes to successful treatment.” (Höschl et al. 2002, p. 40)

Psychiatrists thus work with two distinct systems of knowledge that complement each other: psychopathological categories that describe the symptoms of the disease, and their neurobiological correlates that explain these symptoms. These two systems play distinct roles in psychiatric practice. The psychopathological categories are instruments to describe the accounts of patients and the patterns of their behaviour and assist in ordering the symptoms into a coherent nosological system. The identification of altered experience and behaviour – which in this interpretative context are considered relevant as symptoms of the illness – represents the first step for subsequent correlation of those findings with the assumed specific alterations on the level of neurobiological processes. The neurobiological categories then fulfill the role of causal explanation of the observed phenomena on the level of neurobiology. This process represents a hermeneutical approach: the categories that structure the reality into a meaningful order are established and subsequently other phenomena are understood through these categories.

Psychiatry, as we have seen, is entrenched in the materialistic paradigm, positivist philosophy and mechanical understanding of the nature, where consciousness is identified with the brain processes and subjective experience is thereby ‘naturalised’ – perception, experience and thought is considered a by-product of neurobiological processes. We can illustrate this approach in a textbook of psychiatry:

“Human behaviour is a product of the functions of the brain systems that allow for perception, memory, attention, emotions, thought and language. In the case of healthy and normal functioning these functions guarantee the optimal adaptation of the individual, his survival and reproduction. These are the most fascinating functions of human brain, resulting and culminating in consciousness.” (Raboch et. Zvolský 2001. p. 18)

The consciousness, psyche, or soul is thus perceived as a mere ‘product’ or more precisely an epiphenomenon of biological processes in the brain:



“The fundamental assumption of contemporary neuroscience is that the behaviour of individual is a reflection of the function of his brain... Frontal lobes are responsible for the control of movement, planning and subsequent response, and thanks to the prefrontal association area, consisting of dorsolateral, orbital-frontal and medial system are responsible for the relation of individual to his environment. Executive functions are part of cognitive functions controlling human behaviour in time, and among these belong adaptive planning, formation of analogies, adherence to social norms, problem solution, adaptation to unexpected changes in the environment, and verbal thought.” (Höschl et al 2002, p. 65-66)

The brain is thus construed as an independent, objective entity, that ‘controls’ and ‘is responsible for’ the behaviour of the individual (n.b. the corporate and industrial metaphors). However, this understanding also represents a crucial shift from correlation to causality: the objective neurobiological processes are in this approach the cause of any subjective experience.

Contemporary neuroscience is dominated by the metaphor of brain as a complex information-processing system understood in analogy to computer networks (which reflects the powerful cultural idiom witnessing the dominance of information technologies in contemporary world). The understanding of the nature of psychosis is explained by one of the psychiatrists to his patients:

“The brain is an incredibly complex dynamic organ, composed of specific neurons – something like nodal points and there are also synapses that connect these neurons. Any of my experiences mean that there are new synapses formed. Schizophrenia is a disorder of information processing that results in the loss of contact with reality. The underlying cause for this defect in information processing is that this complex neuronal network is not connected as correctly as it should be. We test this in a neuropsychological test that loads heavily on the network so that even the hidden defects would manifest and we can see where is the failure located.”

As we saw before, the aim of the diagnostic process is making the disorder visible, which is an evidence of the illness, which in this case consists of ‘incorrectly connected network’. The disorder is then followed on the molecular level in accordance with the widely accepted ‘dopamine hypothesis of schizophrenia.’ This hypothesis explains the mechanisms of some of the psychotic symptoms and is based on the observation that the pharmacological intervention in dopamine signalization alleviates some of them. The identification of the disorder on the level of

neurobiological processes in the brain thus allows for targeted pharmacological treatment. To make the neurobiological processes comprehensible to the patients the psychiatrists explain the relationship of dopamine to the symptoms of the illness in following way:

“Dopamine is a neuromediator which mediates the exchange of information between neurons. Neurons talk with each other, and as one of them sends the dopamine out, the other receives them. In order to process and transmit the message, the neuron has to have a dopamine receptor or a receiver. And while in a normal state the amount of dopamine issued by a cell is regulated so that the receiving cell is able to process correctly this information. When the dopamine level increases the receiving cell is not able to process the information and as a result the symptoms of psychosis occur.”

Since the treatment of schizophrenia is a long term and often complicated process, the collaboration of patients in the process of therapy is considered essential. The psychiatrists are of the opinion that patients must know what is going on in their brains in order to understand the nature of their illness and the need for the therapeutic intervention and that this knowledge also helps them to cope with their illness. In order to facilitate this collaboration they created an education programme that explains and illuminates the complex neurobiological processes in an accessible way, using various analogies and metaphors. In these explanations the doctors often use combination of various motives from the various explanatory levels – which they strictly discriminate in the expert discourse – and create a linear narrative structure that employs motives from various levels. Even here the shift from ‘correlation’ to ‘causality’ occurs: the molecules are the cause of specific behaviour. In the session on the treatment of psychosis the physician explains to the patients:

“Let’s consider again how the psychosis occurs. The psychosis represents shift in the perception and understanding of the outside world and is caused by a single biochemical deviation of dopamine which is released in various parts of the brain, for example in the limbic system. Dopamine is essential for attribution of significance to things and it functions like a filter for distinguishing between what is important and what is not. When the dopamine gets out of control the results is a random attribution of significance to things around us, for example different inscriptions or colours of the cars... The antipsychotic drugs block the protein receptors for dopamine, they just sit on them and do not allow this crazy dopamine to attribute significance to things that are not worthy of that. Although we cannot influence the dopamine going mad we can prevent him from causing psychosis by blocking these receptors. The

antipsychotic medication therefore brings the dopamine under control, and that is how you regain the contact with reality.”

It is also noteworthy that the doctors sometimes use the same expressions to describe the various levels of description of illness. The following quotation where the psychiatrist does not refer to the ‘brain’ overwhelmed by information, but the ‘person’ illustrates this:

“In the acute stage of psychosis the person is so overwhelmed by information that they are unable to order it, to tidy it up, and therefore they are also unable to store it in his memory so that there would be any kind of logic in this order. And this results in total chaos.”

The disorder on these various levels (behaviour, brain, neurotransmitters) are described in the same terms: the processing of information on the synaptic level is as disordered as the processing of information on the conscious level and chaotic behaviour corresponds to the chaotic cellular signalization.

However, neither the psychiatrists nor the patients are consistent in which of these levels of description is considered primary and which is derived – sometimes the cause of the behaviour is the patient, sometimes the illness, sometimes the dopamine. This inconsistency allows them to adapt the understanding of illness to a particular situation. On a closer examination of the situations in which the agency is attributed to the patients and to those in which it is attributed to the illness, it seems that this delimitation actually represents the distinction between the normal and the pathological: in order to explain the unusual, abnormal or pathological behaviour, agency is attributed to the illness (or brain or dopamine), in the case of usual or normal behaviour the patient is identified as the deliberate agent of his action. This externalisation of agency – although a product of the inconsistency of psychiatric epistemology – plays a crucial role for the self-understanding of patients, as shall be evident from following discussion.

*... my dopamine has gone mad...*

“It all felt much more real than normally. It was all much more charged with emotions. I just got this attack, this horrible attack and I started crying out for help and I suddenly felt I am completely empty. There is nothing left in my head, and all my thoughts were falling apart and I could not concentrate. I could not understand and comprehend what is going on.”

This intensity and incomprehensibility of the psychotic experience that eludes the usual experience of the world was repeated in the accounts of the many other patients. Another patient who experienced auditory hallucinations recalls the nature of voices he has been hearing, and how real they were to her:

“At first the voices were positive, flattering, soothing voices. Of course I did not mind that. But it was just a way how to get me on their side, and over the time they transformed into negative, hateful, and aggressive against me. You know, when they are catching a bird, they sing him nice songs.”

In some cases the intensity of the experience might be extremely destructive and it is not rare that patients attempt to take their life to escape these overwhelming feelings:

*“It was like if all the earth burns off and what you are left with is hell.”* Other patients refer to their experience as death, a complete annihilation of everything.

Patients in the acute state of psychosis are often rather confused, somehow disconnected from the actual moment, unable to reflect on what is going on, overwhelmed with the impressions and feelings. When they are hospitalised in this state they do not consider their perception and cognition as distorted, and therefore a symptom of the illness, since their experience of reality is equally real to them as any experience of reality. Another patient recalls:

“While you are there, in the acute state, you are unaware of that, you are unable to observe yourself realistically... You live in a different world, in a different reality that you entirely consider to be true. You are unable to do anything. So here I was, in a different reality.”

In these accounts the illness becomes a ‘different reality’, or ‘another space’ into which the patient enter and which they hopefully leave again. These are two different states in between which there might be a certain continuity, but which nevertheless are quite distinctive.

“While you experience it you unconditionally believe that this is real, it means, you are completely unaware that the reality is different in fact. But you understand that only later, once the process of healing gets started through the medication. While you live in that attack, in that psychosis you do not know you are actually drowning in the psychosis, you believe this other reality, and so you do not realize it is not real. In the beginning it was rather inconspicuous. I felt like I am sensing things differently. It was rather like an invisible veil which I actually still see – the surrounding is almost distant, like through a glass. And then the illness got its proper force. I started like the fear was growing in me and I got very anxious about my family. I thought we are all under surveillance and might be attacked... I refused medical treatment, and my parents in collaboration with my psychiatrist took me to the hospital. And here, talking with me and my family, and through some other tests, they uncovered this diagnosis, that it is an acute psychotic attack. And then I was given the right medication that treated the psychosis, that regulates the dopamine, and thanks to that I returned to the reality. Only then I was able to see through, to understand that all that was delusion, and I realized that everything I felt, and what I did – it all was nonsense.”

The category of illness also allows patients to draw the distinction between ‘self’ and the ‘illness’ in situations where patients are unable retrospectively to understand their behaviour or accept that as their own. As an illustration I shall introduce an account of a patient who killed his mother while under the influence of voices and in the state of overwhelming dread and confusion. It is an extreme and very rare case which is by no means representative of the occurrence of such acts among patients with schizophrenia – although the intensity and charge of the situation described by this patient might explain the high rate of suicide among people suffering from severe mental disorder. I am including this here since it provides a very clear example of the motive of the externalisation of the illness:

“If you are under the influence of the attack, of the illness, you behave like someone else, you experience it like someone else... So I realise that it was me who has done all that, who experienced that, but I do not identify with that. The problem is, I do not remember this at all, I blacked-out when I jugged the knife to my mother, and when I caused what I caused, so I just can not recall it. I know I thought my mom is a witch and she sips energy from me... I might have heard something like she is a witch, you must kill at least her, or something like that, and so I did fling at my mother and actually I knifed her to death. I first wanted to kill myself because the voices were telling me I must murder for them, sell drugs, well, prostitute, and such things, so I thought I would be their puppet and they would influence me telepathically from a distance – this community of the people that were all against me... In my perspective it is all pure madness, something happened that is impossible to de-happen. I am

sorry for that. On the other hand I did not intend to do it, and it is not, it was not my intention, I loved my mother a lot, and what happened is simply a consequence of the illness that I suffer from... My explanation is that something has gone wrong in my head, some dysfunction, or rather an imbalance of the dopamine, dopamine and serotonin systems in the brain, and because of that what happened happened.”

In this narrative the voices, illness and neurotransmitters represent ‘external forces’ which entirely took over patients behaviour and actions. The patient is using medical categories as an explanation of what is for him otherwise incomprehensible behaviour, and these categories also provide him with the possibility of distancing himself from his own act which he does not consider as intentional or deliberate. In this extreme case the identification of the act as a direct consequence of altered perception and delusional interpretation of reality is key for establishing the exemption of criminal responsibility on grounds of mental disorder.<sup>163</sup>

In some cases patients even personify the illness, the voices as hallucinations – symptoms of psychotic illness – become the voices of the illness itself.

“After I got on this medication, maybe three weeks later, the voices disappeared, the voices of the illness disappeared, and I realized it was all in my head, that it was not the real reality...”

With the fading of the psychotic symptoms, commonly under the influence of pharmacotherapy, the patients slowly gain ‘insight’ and come to the realization that their experience and behaviour was altered in an unusual way. The gain of ‘insight’ by attributing the experience to the illness is in the perspective of psychiatrists a significant milestone in the process of healing. Some of the patients describe this return to reality as a period of weak flashes of doubts while others refer to this as a singular event.

“This insight, this eye-opening, was possibly a gradual phase, and it feels well. It feels very well, because finally you put your feet on the ground again, and you realize it was all nonsense. And now you think, this is over, this cannot happen again, but it is not true of course. It is just because the dopamine is regulated somehow, and if you stop taking the medication, the psychosis might return, and you will be thrown

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<sup>163</sup> A detailed discussion of this case is in the chapter entitled *Trespass, Crime, and Insanity: The Social Life of Categories* which I wrote for the book edited by Ian Harper, Tobias Kelly, Akshay Khanna, *The Clinic and the Court: Law, Medicine and Anthropology*. Cambridge University Press 2015 (included here as Appendix 2).

somewhere where you do not want to be... The feeling of healing, or feeling of relative recovery, it really feels well, positive.”

Some patients describe this moment as a sudden discovery (in contrast to the slow drowning into the illness), others as a result of reflection that requires a lot of courage, since it calls into questions the very experience of oneself. The following example is the account of patient who was recovering from a third attack of psychosis.

“It took maybe a week on haloperidol that you slowly gain this outlook, this insight, that for the first time you permit this thought – and that is the most difficult part of that – that you admit that maybe after all your brain got it wrong. It is the most important step in the treatment that you allow yourself to think that maybe it is not all as it seems to be. And when you take this medication which corrects the dopamine, then you get better, then you recover.”

The experiences and behaviour of patients in the acute state of illness often significantly damages the trust and relationships with other people. The identification of problematic behaviour as a symptom or expression of illness that has distinct biological causes might be a great relief for many of the patients, as well as their relatives, as is evident from the following narrative of one of the patients took her two daughters and ran out from the home, hiding first at their friends house and then wondering around since she thought her husband was attempting to kill them:

“The return after this attack in the first few weeks is extremely difficult. All the relationships are damaged, ruined, and it takes a lot of effort to repair that. You need others. All these feelings of guilt come only later with the insight, when you realize how mistaken you were and how much you have hurt others. My husband somehow managed to reconcile himself with that. He knew it was illness, but the kids were completely astounded by it. It took a long time to regain trust of my older daughter. Now she sees that I am trying hard. I see the doctor regularly and I take my medication, and so the relationship is slowly rectified. It was the easiest after the third attack, surprisingly, because everyone knew by then that it is illness, that it comes and goes, and that it has to be treated, and if it is not it just returns. My husband respected that and only came to see me in the hospital when he knew I would not consider him an enemy anymore, and my parents in law – it took them a while, but now they also understand it is just the illness. At first I thought, someone just spitted this all on me, all this horrible things, and only after the third time I realized it is dopamine, that there are more people who have the same problem, and that the symptoms of the illness are similar, and that the medication is effective, and that I need to continue with that for a long time.”

The distinction between patient and the illness nevertheless often comes with ambivalence about where the line between the illness and the self can actually be drawn, what exactly can be attributed to illness, what to the medication, and what to the personality or character of the patients. This distinction is often of great importance for the family members struggling to find the right approach to the situation, as one mother shares her concerns about her son:

“It is an all penetrating fatigue. It is a great achievement to get up from bed before the noon. I just thought he is lazy but now I am happy to learn that it is a natural part of the recovery process. Sometimes it is hard to tell what is the medication, what is the illness, and what is just him. It is a constant struggle in finding the line of being tolerant to his inertness, and trying to steer him into doing something. He is not responsible. It is hard to tell whether and how to help him, what kind of stimulus he might need and how strong. He is adult man and needs to be independent and yet he needs this care...”

The illness usually affects the balance of the relationship and for patients it is of paramount importance to have a supportive family in order to come into terms with their illness. There are relationships that however do not endure the strain of the illness and the patients are left alone abandoned by their families and in dependence on the institutional care, especially in the case of chronic or recurrent conditions. Nevertheless, in some other cases the family relationships are nevertheless reinforced and strengthened by this ground-shaking experience, although the balance of the relationship seem to be affected always. This is evident especially in cases where it is not a child but a partner who suffers from psychosis. A woman, whose husband attempted suicide under the influence of his voices and as a result of this attempt has been partially paralyzed now for more than twenty years, told me how important it was for her to learn that it was not ill-intended by him but that it was the illness that made him do what he did. The realisation that he did not want to abandon her with their two small children and relieve himself from the responsibility but rather that he was himself completely confused and hopeless about what has happened helped her to come into terms with the situation and provided her with strength to take care of her dependent husband and their young children. She repeatedly emphasized how understanding the illness helped her to reconcile with the whole situation.



The category of illness thus allows patients to view the psychotic experience and the actions associated with it as not coming entirely from their own being but as an external, objective entity. The illness becomes part of natural – although pathological – processes which can be corrected by medical knowledge and medication. Another patient explains her reasons for accepting the medical explanation as useful and plausible:

“The advantage of this explanation is that you can fight it. When I considered this to be something supernatural, I just surrendered. But once you learn it is just physiology, you can do something about that.”

Several other patients told me how important for them it was to learn that their experience is just an illness, that it has a name, and how the diagnosis allowed to disperse all their confusion since it finally fitted into some rational framework. In words of another patient:

“One is afraid of what one does not know. It really helped me to calm down when I realized this has a name. My fears were gone once I learned about the illness, it was such a relief for me, and it helps me not to be frightened by it.”

*...but still, I think there is something like a soul...*

The biomedical explanations of the nature of the disease allow patients to understand the illness which significantly affected their lives and transformed their relationships as an event caused by an external force. This explanation is useful and considered plausible since it allows them to externalise the illness as a cause of experience and behaviour, and to comprehend their own actions in the acute stage as unintended and not deliberate and therefore distance themselves from otherwise unacceptable consequences. Medical explanations of illness thus relieve the patients of the responsibility and in many cases facilitates more positive response of the social environment.

However, this externalisation is achieved through the disownment of their experience which is expelled beyond the limits of ‘normality’ as something unreal,

invalid and void. In the situation where patients want to accept their psychotic experience as something significant and meaningful in their lives and relate to their illness as an experience that testifies something fundamental about life and the world, the categories provided by psychiatry prove to be insufficient or unconvincing and patients search for and create alternative understandings and explanations of their experience. The patients then accept the validity of their psychotic experience and incorporate it into the narrative of their lives. Thereby they interpret it in existential terms which also provides them with other possibilities of responding to it and transforming it.

Some of the patients I interviewed resisted even the possibility of classifying their experience as an illness because in some ways the experience enriched them and enabled them to see and sense things that they were insensitive or blind to before – although they also agreed that in many ways it created significant limitations in their lives. Many of the patients describe losses caused by the illness: loss of friendship, loss of joy, loss of interest and meaningful work, and most significantly, the loss of the future they imagined for themselves. Some of them would refer to the ‘loss of the center of gravity’, or loss of anchorage. Not uncommonly they would describe their transformation as though they do not feel the same as they did before; *“it is almost like I am not myself anymore.”*

Whatever the accounts were about the actual experiences of the patients, the illness represents a transformative event – or rather a transformative process. They would refer to this as ‘shaking the ground under themselves’ or as an ‘exposure of their soul’. This greater sensitivity to and awareness of the fragility of life was certainly the most recurrent motive in their narratives and was commented on also by their families: *“we all have these layers of protection around our souls and they are stripped of that. Everything goes directly to them.”*

Very often patients for whom the course of the illness has been chronic or who never fully recovered from the acute phases of the illness describe their experience in existential or spiritual terms. These patients often resisted the pathological categories of the illness and the medical explanations of its nature as

well as the denial of their own agency in the cause and course of the illness. Their understanding of the illness of course has implications for the ways in which they deal with the experience and how they accept their illness and the limitations it imposes on their lives. The painful negotiation of the symptoms of their illness can be very exhausting and some of them referred to it as a form of spiritual striving. One of the patients, a surgeon, addresses the inadequacy of medicine to address his condition:

“It has been two years now that I feel completely empty as if there is nothing at all inside of me, no inspiration, almost as if I was dead. I wanted to go to India, to a Buddhist monastery for a year. I had to return after two weeks because I was afraid they would just close me in the hospital. I got some medication, antidepressants at first. I took them for a while but then I discontinued. I did not trust the medication. I wanted to manage on my own. Then I got these different ones. I still feel empty, not sure whether the medication helps at all although I feel a little better than a few months ago. Before I felt like I do not feel anything at all. I would still like go to India and transform my life. I have been at home for a year now. I cannot go to work and I feel my life is senseless, in vain. I would really like to return to work, it is very important to me. I used to be in the surgical theatre every day, operating, and maybe this would help me to return to life. I know I have to take the medication now. And although I would just want to run away from all of this, to avoid all this pain, I know I have to learn to accept even the very unpleasant things and overcome the fear. I know everything about this dopamine and serotonin, but I still think that is secondary. I still think there is something like a soul.”

A patient who by virtue of his professional background might be expected to accept the biomedical explanation of the illness is not willing to accept the reductionist approach of medicine which pulverizes the soul into individual neuromediators. The experience of psychosis, the experience of being shaken in the very grounding of his life in its previous taken-for-grantedness actually confirms his understanding that there is a reality that transcends the common sensory experience.

In a similar way that questions the integrity of the biomedical approach, another patient draws a distinction between what we think of as ‘brain’ and ‘soul’:

“It is just amazing how far the science got in understanding the brain, and all these neuromediators, and all the medication that really helps. But I think that the soul is just too complex and too sublime to be captured, and it goes far beyond what we know. We can never entirely understand that.”

The notion of the soul offers a more poetic understanding of human experience than what is captured by the notion of the central nervous system. This seems to reflect the tension between mental illness as a medical and existential condition. Patients are often looking for a meaning that the purely medical approach cannot offer since it addresses only certain aspects of the lived experience. The experience of being shaken in the common-sense understanding of reality by the psychotic experience was something that many of the patients referred to. One of them described this quite eloquently:

“I do think there is more to reality than what is accessible through senses. There is the material nature but there is also the spiritual nature. There is the tangible reality and there is the intangible reality, and this experience gave me insight into that. It opened a small window, like a night glass, to this other reality which we can enter and where everyone is actually present already.”

Psychotic experience distorts the commonly perceived boundaries between what is considered physical and spiritual and breaks through the normal perceptions with a different experience. Various cultures use different categories in which they frame the experience of the fusion between ‘natural’ and ‘supernatural’ reality. In many cultures, however, the boundary between the sensory and the beyond-sensory, the natural and the supernatural is less impenetrable than in the post-Enlightenment European culture and the space in which these dimensions intertwine is often the sphere of religion. It is therefore not surprising that even in the accounts of the patients religious motives were sometimes present. However, in a country where, as I have described, the neurobiological approach to mental illness has a strong tradition traced back to nineteenth century German neurology and where scientific atheism almost completely eradicated religion from the public discourse, this recourse to the religious language and the resistance to purely materialist explanations of the illness – and therefore of human nature – is something rather astonishing and was manifest in various ways. The concentration of religious activities on the wards of the acute hospital was in fact quite noticeable. Patients had Bibles, Buddhist mantras, books on Shamanism and Eastern wisdom on their night tables. I overheard conversations on

the nature of the Trinity and on the origins of Being and some of the patients told me they pray together once the nurses leave in the evening.

This reality deemed unreal by psychiatry was for some patients in fact the more original and primary to the one common, everyday one. A patient who already before the occurrence of psychosis was interested in the Hare Krishna movement interprets his experience in following terms:

“Sometimes it almost feels like an adventure – what I am going through. You start to see people in a completely new light. Sometimes the illness creates a situation for me, when all my perception of outer world is altered for the purpose of reflecting on myself. I fight with this egocentric sensibility and paranoia and I ask myself religious questions, as for example, where I can find a refuge? At the feet of my Master. And I recall the enjoyment of Krishna as described in the Vedic texts. I recall them and follow them in my spirit and suddenly the surroundings completely changes. No one is pursuing me anymore or if I do not like someone I try to use the spiritual means to fight that.”

In this case the psychotic experience is not in contradiction with the explanation of the nature of reality and the essence of human conduct in this Eastern teaching:

“My explanation is that in the Bhagavad Gita there is a verse where a person is confused by false impressions and considers himself to be an agent of actions that are actually conducted by the three qualities of material nature: the Good, the Passion, and the Ignorance. Every person is under the influence of at least one of them, sometimes Good prevails, sometimes Passion, sometimes Ignorance, but these qualities mix with each other, so it is like a marionette. The Marionette master moves the strings and so the arm moves, and these three qualities therefore enact all things that we consider ourselves to do, independently... because seemingly we are free. We have freedom to do whatever we want to, to search for happiness in the material nature, or to search for happiness somewhere in the spiritual realm. We can choose this. We are free to make this choice, but once we make this choice, we act like this marionette.”

This patient as well as some others even uses the motive of a marionette, but in this case it is not the *illness* that pulls the strings – as was present in the accounts of many other patients who were accepting the biomedical explanation of illness – but the *qualities of cosmic knowledge*. Therefore, order is not disrupted as in the case of the medical explanation of the illness. There is disorder, but actually it confirms the transcendent order into which the patients inserts himself and in which light he

interprets his own experience and his life.<sup>164</sup> Religion thus offers for some patients the possibility of endowing their experience with meaning without pathologising it – as does natural science which reduces all of our experience to an epiphenomenon of biological processes. Ellen Corin in her study of the experience of psychosis concludes that these religious symbols offer the possibility of self-reflection and understanding in the context of culturally shared references, which allows for communication of this experience in the wider context of the search for meaning in life whose self-evidence has been shaken by the psychotic experience (Corin 2007). This does not necessarily mean that the patients would become worshipers or members of a religious institution but the religious domain allows them to appropriate and also adapt the collective cultural representations and symbols that allow them to integrate their experience into the coordinates of the transcendent order. Similar patterns have been described in other ethnographies of traditional and modern cultures (Littlewood 1988).

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<sup>164</sup> I mentioned this patient's explanation to the attending psychiatrists whose response was that it seems like the patient's delusions are not completely over yet and she has to increase his antipsychotic medication.

## **Eradication and Dispersion**

The various ways in which the experience of psychosis is interpreted and related to are derived from different ways of understanding and different interpretative and referential frameworks. We saw that while the category of illness in the perspective of psychiatrists has an epistemological character, for patients it often has an ontological and existential character. For the psychiatrists the category of illness is an instrument for structuring the symptoms and is used pragmatically in the diagnostic and treatment processes. For patients the category of illness captures and transforms the unusual experience through which the common understanding of reality and relation to oneself is challenged. It also allows them to make a distinction between the 'self' and the 'illness' which enables them to distance themselves from otherwise incomprehensible or unacceptable experiences. The psychiatrists recall the biomedical model for explaining the origin and nature of the illness. They relieve patients of the 'authorship' of their experience and behaviour and absolve them of the responsibility for their actions in the acute phase of psychosis, i.e. in the domain of pathology. The motives of illness, brain or dopamine shift the understanding of their actions to a different level of explanation and thereby become constitutive for the externalisation of agency. Although these two approaches are theoretically incompatible (as a variations of classical controversy of determinism and free will), both patients and psychiatrists make use of both of them inconsistently – depending on the specific situation.

Both psychiatrists and patients refer to the category of illness in order to identify and explain phenomena that are considered pathological, while retaining the validity of the common understanding of experience and behaviour in terms of intentions, deliberations, and actions. In the context of psychotherapy – which was not addressed here – the psychiatrists nevertheless help the patient to cope with their illness in the context of lived experience, self-understanding, i.e. in existential terms. Psychotherapy in its approach to the process of recovery also emphasizes the possibility of influencing the neurobiological tuning of the organism by adjusting its

environment and self-creation. Although it accepts the basic biomedical paradigm, it turns the causality in opposite direction, from experience to biology. We might therefore conclude that in any case the illness is not an independent entity in terms of nosological realism, but a specific interpretation of human experience and behaviour derived from a particular interpretive context (Coulter 1979; Hacking 1999).

Differences between the categories and the referential and interpretative frameworks which patients and psychiatrists use to describe and explain the psychotic experience has a direct influence over the ways in which the patients come to terms with the illness that threatens the integrity of their personality and disrupts the continuity of their lives. In the first approach the patients externalize the illness and in accordance with the expert knowledge identify the brain, dopamine or schizophrenia as the agent, origin and cause of their experience. This approach allows them to distant themselves from this often very destructive experience and to transform the reality of this experience to the level of physiological – or pathophysiological – processes. The space of this ‘other reality’ opened up by the illness can be left apart from the ‘reality’ of their lives. In the second approach patients retain the validity of their experience that effaces the boundaries between the ‘natural’ and the ‘supernatural’ and integrate the experience into the narrative of their life and their quest for meaning and relation to something that transcends the reality accessible to senses and perception. Especially in the chronic forms of illness the distinction between the self and the illness is not as easily attainable and patients thus turn to other resources to understand their situation.

There seems to be a tendency for using one or the other explanation of the nature of the illness and the important factor for the appropriateness of the category of the illness seems to be the course of the illness, the presence of positive and negative symptoms, and the curability of the condition. The acute psychotic stage is much more readily explicable by dopamine, while in the case of a chronic illness this explanation is not always entirely plausible. The prospect of healing, recovery, or in other words the curability of the condition is therefore an essential factor in the appropriation of the specific explanation of the nature of illness. In cases where the



prospect of complete recovery is a rather distant hope, the patient thus tends to recourse to existential or spiritual interpretations of their experience, of themselves, and even of the nature of the world.

If we adopt a certain distance and bracket the a-priori claims to truth and validity of the biomedical explanation we can see that both the biomedical and existential interpretations are variations of the more general approach to illness. David Parkin describes two possible ways of dealing with illness and misfortune: eradication and dispersion (Parkin 1995). The characteristic trait of the first approach is the elimination or eradication of the objectified cause or agent of the illness through a wide variety of techniques: excision of cancerous mass through surgical lancet, eradication of bacteria by antibiotics, exorcism of the evil spirits. The second approach is characterized by the restitution of balance between a person and their social and natural environment: the integration of the illness within the organism and within larger social context. The two described patterns and strategies of coming to terms with the psychotic experience of patients suffering from schizophrenia – the biomedical and existential approach – and the respective forms of their self-understanding exemplified in their narratives in many ways conform to Parkin's dichotomy. These two approaches use different cultural symbols and patterns, but for both of them it is essential to understand the nature of illness and its integration into a meaningful order to reconcile with the experience that disrupts the integrity and continuity of life.

The curability of the illness then significantly impacts also the social response to the patient's condition. The predominantly young patients I met in the Prague Psychiatric Centre tended to have a favourable prognosis for a complete or at least functional recovery, and they mostly have supportive families and a wider social environment to which they returned after a period of treatment. In contrast, the chronic wards of the Kosmonosy hospital were full of patients who were completely resigned and without any interest at all, not caring about anything and just living their simple existence, slowly disappearing from the world of their families and friends. Many of them either did not have any families at all, others had one which

was either unable or more often unwilling to take care of them, almost as if they would not even claim their lives as their own anymore – and no one else would either.

The two modalities of curability and incurability are detectable throughout the history of psychiatry in this region. In addition to having developed into separate institutions to provide acute treatment and chronic care, this distinction between ‘curable’ and ‘incurable’ conditions also informs social responses to people suffering from mental illness that seem to correlate with Parkin’s distinction on eradication and dispersion. If the eradication of illness is possible and the patients recover, then their integration within their original social world is much more likely. In the case where the eradication of illness is not attainable, the person becomes identical with their illness and those who suffer the incurable illness are isolated and contained in spaces clearly delimited and secluded from the outer world – behind the walls of psychiatric hospitals, sometimes merely waiting for death (Parkin 1995, Littlewood 1999).

## **Chapter 6**

### **Transformations: Death as a Source of Healing**

#### **Dissolving Human Bonds**

When I think about it, my first encounter with psychiatric patients actually preceded my visits to the psychiatric hospitals by several years. It was not patients actually. It was their corpses. They were not introduced to us officially and we did not even know their names. Often we even did not see their faces and we did not care that much, actually. All that was important for us in that time was to find exactly where the ulnar nerve passes the olecranon. Where the femoral artery bifurcates. Which valve is composed of three and which of only two flaps. How many branches stem from the facial nerve. The complexity of the inguinal canal. We did not have time to think about the past of the ten hearts that happened to share the same plastic bucket. Some of them were better – you could see all the structures nice and neat – while others had their coronary arteries clotted and scars all over. We hoped that in the exam we would get one of the nicer ones. Yes, there was so much to learn, so many strange Latin words that were difficult to remember and the more difficult to point to what they refer to. The bodies are so messy under the skin. If you open the skull the only thing you find there is a strange soft mass, greyish, stained with blood. That is supposed to have been the centre of it all. Of all movements, sensations, memories, dreams, once conscious, all present as a complex nets of cells. And now it is over. The only thing that ‘survived’ is this mass of gray and white matter as it is called. Yes, you can still name all the gyri, identify all fifty-two Brodmann’s areas, and if it is well preserved and you cut it carefully, you might even see all the parts hidden bellow the lobes: the thalamus, the hypothalamus and the limbic system, the brain stem, the reticular formation, the superior and inferior folliculi and so on. It is hard to believe it was ever anything more than this messy mass. That those bodies used to be persons with a name, a face and a life. Those unclaimed bodies.

Those bodies dated before 1990, of course. Informed consent was introduced since then and the new law requires that. Only those wishing to devote themselves to science, those who have signed the contract with future effect shall find their eternal peace in one of the containers filled with ethanol. Not eternal, maybe – we should now be rather careful with the category of eternity now since the eternal empire crumbled. But certainly for long enough to allow a young and promising generation of physicians to learn and learn until they are considered learned enough to heal people. To heal the suffering by the means of their knowledge. Knowledge assisted with pills and fluids of various colours and consistences and if necessary, with a scalpel, complex machines, electromagnetic fields and radiation. And not only heal, but also save their lives.

Practicing pathological anatomy dissection on patients dying in the hospitals was common for centuries in many countries. The current law in the Czech republic requires a postmortem examination only when the cause of death remains unclear. However, teaching anatomy in medical school requires the use of bodies preserved for the purposes of teaching. Until the introduction of informed consent in 1990 the law allowed for the use of ‘unclaimed bodies’ for purposes of medical research and education. When I asked our professor of anatomy whose were the bodies we dissected, he replied that most likely these were patients from one of the psychiatric hospitals or long-term hospitals for the elderly. He explained that this has been a common practice possibly for centuries and in addition to the unidentified bodies left over from the wars, these institutions were the main supply for anatomical departments. Only recently have they had to rely on donors who come and sign their donation card while they are still alive.

I was unable to locate the historical and legal origins of the practice of resourcing the bodies of patients who died in hospitals. It was suggested to me by a professor of internal medicine that the practice was first institutionalized by Maria Theresa of Austria as a law claiming that a dead body belongs to the state (more in Tinková 2010). This law was supposedly introduced in order to prevent further escalation of the epidemics – as a response to the hesitation of some to bury their

relatives in appropriate places. The earliest mention in law I could find of the delivery of pathological-anatomical material to the universities dates from 1853.<sup>165</sup> However, this provision does not include any specific explanation which suggests that there was an earlier version of a similar law.<sup>166</sup>

A law from 1883 addresses the delivery of corpses from the country to the anatomical institutes and specifies the timing of the delivery (it must not extend beyond the common period for burial), issues of transport in the coffin by railway (preferably at night), the specific procedures for the conservation of the body as well as the burial of the ‘soft tissues’ in a local cemetery. This law resulted from a negotiation between the Ministry of Health and the Ministry for Spiritual Matters and specifies the responsibilities of both hospitals and the anatomical institutes. Also, this law does not address pathological dissection which was a common practice then and was regulated by different law – the corpses susceptible to infection were exempted from this law.

Another legal provision dates from 1905 and is addressed to the medical schools. This law regulates the transactions and commerce with material obtained from human corpses and specifies that these can be used only for educational and research purposes.<sup>167</sup> Laws from 1927 and 1930 address the delivery of ‘unclaimed bodies’ to the anatomical institutes from the prisons and psychiatric hospitals respectively: *“If during the period designated for the burial no relatives express their interest in the body, the corpse is to be considered unclaimed.”* The law from 1930 addresses the issues of the identification of the corpse (each corpse was given a passport including their name, age, profession, place, date and cause of death and the information about the potential postmortem), the type of coffin to be used for this

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<sup>165</sup> Nařízení min. k. a v. ze dne 5. ledna 1853, čís. 9 ř. z. This law refers to anatomical items obtained from human corpses and included also ‘monsters’, i.e. babies born with various deformities and lacking human features. These babies were long considered to not possess a soul.

<sup>166</sup> There is also a legal continuity of the ownership of the body by the state in the presumed consent for transplantation of organs in countries of former Habsburg empire. For more on the situation in Hungary see Blaszaeur 1998 and in Poland see Szawarski 1998 who argues for the ‘ethics of solidarity’ as a basis and moral justification for the donation of organs.

<sup>167</sup> Výnos min. k. a v. ze dne 18. ledna 1905, č. 510-KUM ex 1904 MVB č. 10, o obchodu s anatomickými preparáty pořízenými z lidských mrtvol (děkanstvím všech lékařských fakult).

purpose (metal or wood coffin in an additional wooden box, disinfected) and the means of transport (by car, possibly at night). The ‘unused corpses’ were to be buried immediately after receiving the information that they are not needed.<sup>168</sup> The addendum of this law also specified that the bodies of German origin are to be delivered to the anatomical department of the Prague German University, while the bodies of Czech origin to the anatomical department of the Prague Charles University. The bodies of Jewish origin were – on the request of Jewish community – exempted from these provisions as well as from the obligatory postmortem.



Discarded microscope from the pathology laboratory, Bohnice hospital, 2007

These legal provisions were amended only in 1966 by a law on funerals that instituted an exception to burial so that dead bodies could be used in medical research or for educational purposes:

“The bodies of the deceased who expressed their consent before death or whose identity is impossible to establish. For these purposes also the bodies of the dead of

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<sup>168</sup> 16. září 1930, č. 17.083

whom within 96 hours after their death nobody expressed interest in their burial after their close persons [i.e. next of kin or known friends] were informed in time.”<sup>169</sup>

The status of unclaimed bodies was thus determined by the lack of human bonds while the patients were still alive. The dissolution of human bonds and kinship obligation signifies the status of the deceased as ‘unclaimed’. This practice therefore allowed for the transformation of ‘unclaimed’ bodies into ‘useful’ bodies that serve the purpose of gaining medical knowledge.

It is also interesting to examine the perspective of the medical profession, especially the anatomists, with regard to these laws. Writing in the early 1980s the anatomy professor of Brno University Lubomír Malinovský comments in his article *On Obtaining the Bodies of the Dead for Scientific and Educational Purposes* on the problematical aspects of this legal provision. He complains that there are virtually no voluntary donors which might be attributed to three factors: the unfortunate, persisting influence of the religion, especially that of the Catholic church which claims that the dead body belongs to the Earth and should be buried and also influences the commonly held view that the anatomical dissection is on the very margins of the law and the morals; the good social conditions where the state provides financial contribution for the burial; and the inadequate education of the citizens on their obligation to the state – citizens perceive healthcare as provided for free and do not consider themselves obliged to serve the society by their bodies and blood. The author then complains that the number of unidentified dead went down since the end of the WWII which provided anatomical departments for some time. He devotes several paragraphs to describing the situation of the ‘unclaimed bodies’ and makes explicit some of the assumptions that make this practice possible and therefore I shall include them here in full length.

“The provision that the bodies of dead persons for whom nobody expresses interest in within 96 hours despite the close persons being notified in time, unless the deceased has not made an order regarding the funeral, gives us the greatest opportunity to obtain the bodies of the deceased. However even here we are strongly limited:

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<sup>169</sup> Vyhláška ministerstva zdravotnictví č.47 ze dne 13. června 1966 o pohřebnictví. Paragraf 10, čl. 1

- a. By the financial contributions of the state for the funeral. The lack of interest mostly concerns only far relatives. The practice nevertheless brings uncomfortable difficulties. One of the institutions delivered us a body of a deceased man for whom nobody expressed interest. Because it was a body of young man the corpse was used for a skeleton. After six months a brother of the deceased came to us and requested the body for a funeral. On my notification that in the stipulated period he did not express his interest in the body of the deceased, he argued that the institution made very little effort to find his address and notify him. He threatened us by filing a complaint at the highest possible offices. It was of course impossible to release the remains. We also could not allow him to raise his complaints, as the predictable consequence would be that the institution would not advance us any more bodies in order to avoid potential troubles. We therefore decided to have a friendly and patient conversation with this man in which we managed to calm him down and also convince him that the use of the body of the deceased for scientific purposes is a highly dignified legacy.
- b. The formulation “unless the deceased did not make arrangement for the funeral”. The arrangement for the funeral can be interpreted as a will expressed either in writing or in the presence of witnesses. This grants us a certain opportunity to obtain bodies from the medical institutions for chronically ill patients, i.e. bodies of persons who do not have anyone or for whom their relatives do not express any interest, because it is exactly these persons who in many cases do not formulate any will or arrange for their funerals. In contrast to this, in the houses for the elderly we encounter multiple problems. The first is the application form for the placement for the institution for the elderly, specifically page 3 where the number 20, 21 and 22 requests the applicant to state their arrangement regarding the funeral. A significant obstacle for us is also the self-governing groups in these institutions who often arrange for the funerals of their deceased roommates. Sometimes even the director of the institution seems to accept this solution because it is somehow easier. Nevertheless we are still successful in obtaining the necessary number of bodies for dissection. This is however only thanks to the understanding of individual directors (there are significant differences) and our systematic efforts at persuasion. The directive only states this as an option rather than an obligation of the medical or social care staff.

Who is then responsible for the provision and organisation of obtaining bodies of the deceased for scientific and educational purposes? Who is obliged to this by a duty stipulated by the law? Unfortunately there is no specific directive about this provision. The procurement of the bodies of the deceased for scientific and educational purposes for the anatomical departments is therefore left to their directors based on their traditional networks as has always been the case in earlier



centuries. This duty and obligation is thus dependent on the moral responsibility of the anatomists for leading in the interests of society and its healthcare.”<sup>170</sup>

There are several interesting things about this article. First, medicine is construed as a service to the society in whose name practices such as anatomical research and education are undertaken and physicians are fulfilling their ‘moral responsibility’ by providing conditions to make these practices possible. Second, the ties of kinship – whether of natural families or created by shared condition (as in the example of elderly people living in an institution and providing for their dead where there is no family present) – are seen as an obstacle for this dignified endeavour. Third, the status of people who because of their chronic condition die in institutions providing long term care are clearly the most obvious targets for such practices since there is no one who would care about their bodies after death – as there was no one to care about them while they were still alive. As in earlier centuries the communities and the state are absolved from their obligation to bury the dead in cases where their bodies can be used for medical purposes.

The utilitarian argument employed to legitimize the practice is obvious and the author does not even consider it necessary to state that reasoning explicitly. The corpses of those people are sacrificed for the common good. Their individuality and their name is erased as they are transformed into a specimen from which medical knowledge can be gained. As the history of anatomy illustrates the persons who suited well the purpose often represented groups that were already socially marginalized or excluded – convicts and especially those condemned to death sentence, prostitutes, and the mentally ill. The impurity of their status – their liminal state – is transformed into an instrument of knowledge, and subsequently into a means of healing. This transformation from the most destitute state to one of social utility is achieved by the work of medicine which represents the only context within which these practices are conceivable and justifiable.

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<sup>170</sup> L. Malinovský. K problematice získávání těl zemřelých pro vědecké a výukové účely. [On the obtaining of bodies of the dead for scientific and educational purposes]. Unpublished manuscript provided by Professor Josef Štingl, head of the Anatomy department at Third Faculty of Medicine, Charles University in Prague to whom I am indebted for the information on the obtaining of bodies in anatomical departments.

There are several assumptions behind these practices which are derived from specific epistemological positions about the nature of the human body and soul, and about the permissibility of breaching the integrity of the body for various purposes as a result of which the corpses are not buried but used for other ends. With the help of the historians of anatomy I will now try to examine the relevance of these shifts for understanding of these practices in modern science and medicine.

## Death and Redemption

In *Books of the Body*, a study of the development of anatomical dissections in Rome in early Renaissance Italy, the historian Andrea Carlino describes and analyses the development of practices surrounding the use of the bodies for medical purposes, a practice that was previously strongly taboo (Carlino 1999). He examines the conditions that made this practice possible, the rituals that developed to structure the ambiguous practices.

“It seems clear that the procurement and cutting open of cadavers for scientific (thus profane) purposes and the inevitable delay in the burial of the dead that followed, were considered religiously and anthropologically dangerous acts. ... The norms governing the practice of public anatomies in the Studium Urbis in the sixteenth century, the criteria that were followed for the selection of the subjects of dissection, and the procedures and acts before, during, and after the desecration of the remains, emerge as a series of prudent strategies implemented to limit the circumstances under which anatomical demonstration could be legitimately allowed. Dissection is not in itself an innocent act. Its practice requires, on the one hand, a legitimizing epistemological and institutional context and, on the other, the elaboration of rituals, strategies, and mechanisms to filter out its transgressive and sacrilegious connotations.” (Carlino 1999, p. 3 and 226)

The transgression that the opening of a cadaver represented in the religious context – which presumed a specific understanding of the relation of the immortal soul to the mortal body – was transformed into a secular practice justified on utilitarian grounds. This transition was not entirely straightforward but once established as legitimate it remained unquestioned for many centuries to come. The ambiguity of these anatomical practices required the collaboration of physicians, universities, religious and political authorities to make the practice of dissection not only possible but also legitimate. Carlino writes:

“The limited opportunities for using anatomical knowledge in healing left a lot of room, moreover, for the persistence of an unease (that took different forms in different contexts) generated through the centuries by the handling and profanation of the remains of the dead. The acts connected with anatomical practice required a strong and recognizable motivation if they were to be made legitimate. The extraordinary continuity between ancient and modern arguments and the qualms over the practice is astonishing. The manner of their expression and the adoption of certain rituals in Renaissance anatomy suggests that they were generated by a

common fear of contamination by the proximity to the impure and malodorous bodies of the deceased in funerary practice. This contact affected the physician and the young student alike, and they managed to overcome their revulsion toward the cadaver only by fulfilling the objectives of the profession. This attitude also affected society as a whole, which continued to hold the opening up of the body as a dishonorable and sacrilegious event.” (Carlino 1999, p. 6-7)

As Carlino describes, the transgressive behaviour is set within the ancient categories of impurity and contagion. It was not any body that could be used for the purpose of anatomical studies – for centuries the possibility to use someone’s dead body as a cadaver corresponded to their status of committing great sin, a crime, and being condemned to death.

“Their bodies, punished and damned, would continue in their agony even beyond life, since their souls would pay in the hereafter for the sins that they had committed. The status of these bodies nonetheless appears special: they were marginalized, banished from the society, no longer the dwelling of the sacred; at the very moment of their sin it seems as if the people who later become the subject of dissection lost, along with their lives, the dignity that the integrity of their remains conferred. The association of dissection with sin or transgression shows itself first in the surreptitious and irregular practices carried on at the boundary between the licit and the illicit. Later, unable to evolve otherwise, such practices were codified in formally expressed and normative texts made necessary when they began to spread and gather momentum. The statutes show how anatomy advanced into the realm of the legitimate through formalization and ritualization.” (Carlino 1999, p. 93-94)

Carlino describes the additional criteria that developed with respect to the selection of the objects of dissection in different medical centers. In Padua, the condemned had to be selected from outside Paduan or Venetian territory. In Florence, the caveat was that anatomy was not to be performed on the body of any Florentine or Pisan citizen, or of any Doctor or student. In Bologna the condemned had to come from at least thirty miles from the city, and the person must not be of ‘honorable birth’, and similar rules applied in Perugia and Genoa. In Rome the decree was issued that the public anatomies were to be conducted ‘*on the bodies of Jews or other infidels who have been publicly executed.*’ Carlino suggests that these injunctions support a hypothesis: ‘*the anatomist’s scalpel was to be used on the bodies of marginalized, ignoble, and despised people so as to avoid prejudicing, as much as possible, the sentiments of Christian piety and the practice of forgiveness.*’

There seems to be a great consistency and persistence in the pattern of the association between transgression, social exclusion, and the availability for medical purposes on behalf of the society.<sup>171</sup> The person had to be of low birth, possibly from the foreign community or territory, and although at this stage the practice might be considered ‘punishment’ and further retribution to be inflicted on the condemned, it nevertheless created conditions for other interpretations of the practice.<sup>172</sup> Even in this Christian context the practice was not entirely in line with other principles of Christian doctrine and Carlino describes several charitable initiatives aimed to counter and recover this practice by providing comfort and support to persons condemned to death. Although the condemned could not know which of them would be provided for this offering, they seemed to live in fear that their bodies *‘would be given to physicians to do anatomy and this provoked great anguish. They believed that a body thus profaned and disfigured could not hope to be recomposed on the day of the final resurrection.’* (Carlino 1999, p. 100)

Carlino describes in detail the process of preparation for and conduct of the execution. This included the encouragement of the convicts to repent of their sins to the merciful brethren, provide absolution and last prayers in the chapel, and after the execution the body was accompanied by the procession of merciful brethren to the hanging from the bridge of Saint Angelo. The merciful brethren also celebrated the Mass on behalf of this person. The ritual was however different if the condemned person was to be given to the anatomists: the body was taken by the anatomist and this had to take place during the night at the place out of sight – in the church of San Giovanni Cecollato. The process had to be thoroughly recorded under the aegis of judicial authorities indicating who was responsible for the body at which point and the process had to follow a strict order. The anonymity of the body had to be preserved. What is nevertheless very interesting is the provision of 1536 that, at the completion of the anatomy, funerary rituals had to be performed and at least *twenty*

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<sup>171</sup> A similar pattern was analysed by Lawrence Cohen who developed the notion of ‘bioavailability’ for based on his research in India (Cohen 1999).

<sup>172</sup> Carlino also speculates on the association of the earlier practice of ‘quartering’ the body as a post-mortem punitive action for especially severe crimes, and these bodies were also then strewn unburied in the countryside, deprived of any hope for salvation for their souls.

Masses celebrated for the soul of the condemned person. In the theology of that time the soul of the repentant and contrite person would go to Paradise or to the Purgatory, depending on whether they had time to expiate for their transgression. Hell welcomed those who persisted in their sins – mostly as unbelievers or heretics. The teaching on Purgatory was not part of the early Christian doctrine but developed to provide hope for divine pardon for sins that were originally considered beyond salvation (such as homicide, sodomy etc.). This conception of divine justice allowed for hope for the possibility of redemption. The painful passage through Purgatory could be shortened by the intercession of the living, and possibly that is why the merciful brethren would act on their behalf by prayers, charity, and the celebration of Masses. The clothing of the executed person was sold by the confraternity one week after the execution and the proceeds distributed as charity to the poor in the name of the departed soul.

Carlino interprets the practice as an *'attempt to reward the soul that inhabited the body used by the anatomists for the services it had rendered to the physicians and to science by shortening its possible sojourn in Purgatory'* (p. 113). He also suggests that the cutting up of the body for a profane purpose resulted in a higher infamy and also significantly delayed the burial and therefore the intensification of the intercession was to relieve the soul of the prolonged suffering. The practice nevertheless could have also an unfavourable impact on the souls of the physicians and students participating on the anatomy – the concern for their own destinies led to the practice of collecting fees for attendance and donations for the charitable service of the fraternity to the poor. By doing so they possibly also dissolve themselves from the moral and religious implication of the transgression they committed by performing the anatomy.

“This interpretation implies that the violation of a body, and with greater reason, of a cadaver, was certainly not an operation without religious and cultural consequences (at least in the way it would be perceived outside the narrow circle of those who performed it). The acts of intercession performed by the physician-anatomist and specified in the university statutes thus assume the character of rites intended to absolve both the physician and the dissected subject from possible attribution of impiety and transgression resulting from certain acts carried out during the dissection.” (Carlino 1999, p. 114)

However, Carlino also notes that these conventions constitute a formal system required to legitimize the practice of dissection which nevertheless was not observed in practice. The science and religion developed competing demands regarding the dead: showing respect toward the dead and gaining a knowledge of human body which might be considered a sacrilegious act. The formal rules that were nevertheless not observed actually achieved their original purpose: to legitimize practices aimed to establish knowledge of human body as a foundation of all medical practice that would be seen as a sufficient guarantee of the morality and lawfulness of the work of the anatomist. The observance of religious practices thus prepared the way of legitimising the practice in its own terms – as a science.

Another anatomy historian, Ruth Richardson, describes the period between death and burial as a very ambiguous transitional state, where the human being was regarded as neither alive and nor fully dead, and describes the rituals of purification of the corpse after the person died (Richardson 2000). The ambiguity of the cadaver used for dissection mirrors the ambiguity of the social status of the person while they were still alive. The closeness of death and the liminal status of those who were considered eligible for serving the purpose of becoming objects of medical science are thus closely intertwined. Medicine enters the spaces of social exclusion, transforms the death into science and distills it into knowledge that has a power to save life and to heal: the secular sacrifice that at once transforms bodies that shared the condition of impurity while still alive and provides the cure by means of medical science. Carlino observes:

“The resistance to the practice of dissection and the accusation directed against anatomists in the sixteenth century was of the same sort as that voiced many centuries earlier by opponents of anatomy. Their semantic context, from ancient Greece to Catholic and Protestant Europe at the close of the sixteenth century is anthropological; it relates to the fear of contamination and filth connected with the handling of cadavers and with the detaching of parts of the body. The notion of foulness that recurs across the centuries is crucial in this regard. At the same time it is precisely the impurity of the decomposing body that determined the funerary practices, the distancing of the cadaver from the community, and the marginalization of the trades connected with death, the carrier of contagion.” (Carlino 1999, p. 229)

The fact that this ambiguous practice of sourcing bodies from the most marginalized persons continued and remained unquestioned until quite recently deserves analysis. Prisoners were the most readily available ‘objects’ or ‘subjects’ for anatomy and medical experimentation in general and it was only during the war with the extreme excesses of experimentation in concentration camps during the WWII that the practice became regulated. However, until 1960 even in the US prisoners remained the population of choice for medical experiments, especially clinical trials, since the conditions were easily controlled. The use of poor people and of unclaimed bodies from public hospitals has also been universal practice which dates back as long as these hospitals were institutionalized to take care of population unable to afford medical care and has been documented in detail by historians (Richardson 2000; MacDonald 2006, 2010; Risse 1999). Mentally ill patients seem to have suffered this destiny more often than others, at least in the geographical region that is the subject of my research, but this tendency has been persistent in other contexts as well (MacDonald 2011).

The shift from understanding the human body in religious terms to material terms was partially enabled through the practice of dissection but in some cases also vivisection and experiments on the human body as part of the empirical and experimental medical science. The practice spread through European universities in the sixteenth century although anatomical knowledge did not necessarily contribute to progress in the medical treatment for centuries. Nevertheless, it contributed to the establishment of the modern understanding of the nature of man, of secular metaphysics. The previously described anatomical and neurobiological ‘anthropology’ can be seen as a culmination of the process initiated many centuries ago and until today serves as a ‘rite of passage’ or initiation for the students of medicine. However, as Carlino concludes:

“Dissection is not in itself an innocent act. Its practices requires, on the one hand, a legitimizing epistemological and institutional context and, on the other, the elaboration of rituals, strategies, and mechanisms to filter out its transgressive and sacrilegious connotations” (Carlino 1999, p. 226).



The neutralization of the ambiguous moral space by the apparently neutral science has been mostly successful in the expert domain, but nevertheless the practice remains a source of unease. As Steven Shapin, a historian of science comments: *'Uneasily positioned between the profane and the sacred, the corpse is venerated, abominated and feared. Sometimes we do science with it; more often we shudder and pass by on the other side.'* (Shapin 2011)

This transformation of the religious into the medical has been identified in other contexts. David Parkin observes in a context of Islam: *'many medical practices are embedded in religious acts, and many of the latter are couched in the vocabulary of cure.'* (Parkin 2007). We can therefore conceptualize medical dissection as a sacrificial act since its purpose is not dissimilar to that of sacrifice in other contexts, albeit devoid of obvious religious meaning. In an introduction to the book *Death and the Regeneration of Life* Maurice Bloch and Jonathan Parry state:

“The logic of Hindu sacrifice rests on the implicit assumption that a life must be relinquished if life is to be attained. It is clear that such conceptions imply that death is a source of life. Every death makes available a new potentiality for life, and one creature's loss is another's gain.” (Bloch and Parry 1983, p.8).

Furthermore, these authors also focus on the association of death and the legitimization of authority and its ideological constructions:

“The transcendent authority of the Brahmans, who sacralise the social order, is reinforced by the theory of death as a cosmogenic sacrifice, for this theory locates the ultimate source of regenerative power in the ritual sphere, and places its control in the hands of those who operate the sacrifice.” (Bloch and Parry 1983, p. 41)

In the context of medicine these motives are evident from the already mentioned 1981 book on the importance of anatomy for the formation of the scientific worldview and for the betterment of the social conditions by the communist professor of anatomy, Lubomír Malinovský. In his introduction to the book, Malinovský states:

“Science is one of the forms of social consciousness whose purpose is the knowledge of nature and society and the discovery of laws that govern these. The task of the natural sciences which include medicine is the uncovering of natural laws and their utilization for the development of society.” (Malinovský 1981, p. 9)

This transcendental order of nature that science discovers and uses for the purposes of society at the same time legitimizes the social order and governance. This interpretation of Marxist materialist philosophy – which stipulates the unity of the laws of natural and social science – provides justification for these ambiguous practices in the name of science. The medics who have privileged access to the human body are thus ascribed an important role in the improvement of human life and society. The violation of human bodies would be considered a criminal activity outside the medical context, and the medicalization of the violence that necessarily accompanies the anatomical dissection provides the legitimation of such practices. The medical space is exempted from other spaces and the privileged position endows the medics with impunity. The utilitarian justification allows the violence to be seen as meritorious acts on behalf of society: the conquest of natural forces for the benefit of the society.

These crucial secular medical practices thus paradoxically retained some of the quasi-religious characteristics and motives which it sought to eliminate. The study of anatomy contributed to the materialistic metaphysics of the post-Enlightenment period which culminated in Marxist philosophy but in the process it unwittingly utilizes some of the most essential religious motives: the creation of the transcendental order of scientific evidence replaced the transcendental order of religious cosmology; the experiments replaced divination; and the redemptive power of knowledge replaced the divine powers capable of restoring and preserving life. Medicine has replaced religion in mediating between life and death – the secular hospitals now represent environment in which majority of European population is born and dies.

Moreover, medicine has also gradually substituted religion as an answer to human suffering. To a certain degree they now coexist as alternative ways of coming to terms with illness, hopelessness and death. In a country that has absorbed Marxist ideology that aimed to eradicate religion, medicine was the only available answer to illness. The practice of anatomical dissection has been crucial in the project of modern science and is a vehicle of secularization. If we adopt another perspective,

however, we might conceptualize this practice as a form of secular sacrifice – paradoxically an act of highly religious significance. As Marcel Mauss and Henri Hubert observe, *‘sickness, death and sin are identical from the religious point of view’* (Mauss et Hubert 1973). Giving up the bodies of impure people for the knowledge that is distilled off of them becomes a ritual of catharsis, where the knowledge gained can be a source of healing. By becoming an object of medical science their bodies are purified and thereby redeemed of their sin, crime, or illness.

Coming back to the David Parkin’s dichotomy of eradication and dispersion, the contours of these practices resonate well with the that of medical practices and opens up another dimension in understanding them. The eradication of the illness achieved through the use of the diseased body or in extreme cases the eradication of its bearers whose bodies are then ‘sacrificed’ – is transformed through the power to cure and eliminate illnesses of other patients. This ‘economy of sacrifice’ can be identified throughout the history of modern medicine from the first attempts on anatomical dissections to the latest pharmaceutical trials, transforming the ‘incurable’ into ‘curable’. The principle of substitution allows for the hope of redemption.

The transfiguration of the impure into the potential to purify and heal reflects the omnipresent ambivalence and ambiguity present in religious practices. As Henri Hubert and Marcel Mauss in their famous essay observe:

“It is indeed because what is pure and what is impure are not mutually exclusive opposites, they are two aspects of religious reality. The religious forces are characterized by their intensity, their importance, their dignity, consequently they are separated. Ambiguity of the religious forces themselves can tend to both good and evil, the victim represents death as well as life, illness as well as health, sin as well as virtue, falsity as well as truth. It is the means of concentration of religious feeling, it expresses it, incarnates it, carries it along.” (Mauss et Hubert 1973)

The corpses from which anatomical knowledge is gained, the animals sacrificed in medical experiments, and even the bodies of living patients who become subjects of experimental treatments are substituted for the life of the sick who will benefit from the knowledge and treatment gained through these practices (Lynch 1988). The evocation of sacrifice with respect to the ‘defective’, ‘impure’ and ‘compromised’

bodies of psychiatric patients and other categories of undesirable people and the use of their bodies for medical research has been widespread practice until recently. It might therefore be possible to transpose Giorgio Agamben's *Homo Sacer* thesis into 'life that can be sacrificed but not killed'.

The sacrifice maintains and repairs the cosmic order, and Maurice Bloch further establishes that it is sacrifice that gives the sacrificer power and wisdom (Bloch 1992). The role of the anatomical dissection in the initiation and training of physicians and their participation on scientific experimentation as well the consummation of the distilled knowledge in the form of medication that has power to heal seems to provide evidence for viewing these practices as religious practices.<sup>173</sup>

The motives of sacrifice in its more extreme are identifiable in the practices of Nazi medicine. The famous German neurologist and professor of Heidelberg University, Viktor von Weizsäcker, who later became associated with the psychosomatic orientation of psychiatry, observed that physician's role is not only with the support of health but also the elimination of pathology and even termination of life. He advocated that the physician's role extends beyond treatment and cure and indicates surgery and abortion as examples of the necessary tasks of medicine. However there is also a hierarchy of value in medicine: *'From the physician's point of view it is clear that a healthy life has more value than a sick one.'* (Weizsäcker 1986-2005; 7:99) Utilizing the metaphor of society as an organism where the diseased parts potentially endanger the healthier parts he draws an analogy between the role of physician towards the individual and that of the politician and society. The responsibility for health and for racial purity of the nation extends to the role of physician in the society. In 1933 Weizsäcker wrote:

"As physicians, too, we hold responsibility to play a role in the sacrifice of individuals for the common good. It would be illusory and, indeed, it would not even be fair if the German doctor believed himself above playing his responsible role in this emergency policy of destruction" (Weizsäcker 1986-2005; 5:323)

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<sup>173</sup> In this cultural region it is almost analogous the prayers and healing rituals of Catholic church administered by priests, the transformation of the divine sacrifice in the Eucharist and the role of holy water.

Although it is unclear to what extent Weizsäcker personally participated on the T4 programme of euthanasia of the disabled and mentally ill patients, there is clear evidence that while being a physician researcher at Wrocław University he was using the bodies of young patients euthanized in nearby psychiatric hospital for his research on neurology and psychiatry (Böhme 2007). In his essay *Euthanasia and Experimentation on Humans* he deliberately evokes the notion of sacrifice:

“It is only the notion of sacrifice by virtue of which an action so similar to murder can actually come about. In the notion of sacrifice alone inheres the particular dialectic, which can turn the mere motive into law, an ought, a duty, an inescapable compulsion, a moral action.” (Weizsäcker in Böhme 2007)

In this case the notion of sacrifice extends to the actual killing and extermination and transforms the prohibition into command.

However these practices have been retrospectively considered to have crossed the line of ethical acceptability, it might be argued that it is a question of degree rather than nature. The legal status of their legitimate availability for medical purposes post-mortem was in this case extended to their pre-mortem condition. Given the blurred boundaries of incurable illness and death patients represent the ambivalent status of ‘threatening’ and ‘untouchable’ at the same time. In these cases medicine provided legitimation and utilitarian justification. The dissolution of human bonds and the absence of those whose relationship would preserve and defend their ‘humanity’ makes the incurable patients especially vulnerable to serve various purposes of the society. The utilitarian interpretation and the justification of these practices in terms of moral duty and social responsibility was at that time a widely shared sentiment.<sup>174</sup>

The rise of the materialistic and evolutionary worldview facilitated the treatment of patients as objects of medical science. Being no more than carriers of

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<sup>174</sup> It is well known that it was a psychiatry professor, Alfred Hoche together with law professor Karl Binding, who authored the 1920 book ‘Die Freigabe der Vernichtung Lebensunwerten Lebens’ (translated as ‘Authorization for the Annihilation of Life Unworthy of Being Lived’) that became the basis for the social policies in Germany. It is nevertheless important to emphasize that Eugenics informed other practices not limited to Germany – for example the sterilisation of mentally ill patients that was widely practiced in the US for some time at that point and that remained practiced in Europe well beyond the end of the war. For more see Daniel J. Kevles. *In the Name of Eugenics. Genetics and the Uses of Human Heredity*.

defective genes and disturbed brains, the dignity of severely or incurably ill patient has been denied and they easily became objects of medical practices and problematic social policies. If the humanity of the other person is denied by other people then medicine is unable to save it by any means she is provided with. Medicine indeed plays an important role in transforming the 'incurable' into the 'curable' and by neutralizing the moral space opened up by the illness removes some of the guilt and stigma. Nevertheless, the inherent value hierarchy of 'healthy' and 'ill' or 'defective; does not as such provide the basis for ethics and can actually easily become its very opposite.

## **Concluding remarks – Part II**

### **Therapeutic Environment, In/Curability, and the Disappearance of the Soul**

There are several themes – albeit addressed from different perspectives – that intertwine in the previous chapters and on which I will offer some concluding remarks.

First of these themes is the notion of the therapeutic environment that informed the design and spatial organisation of institutions providing care of patients suffering from mental illness. In the time of the greatest expansion of institutional care – the late nineteenth century – the project of constructing psychiatric hospitals represented an ambitious project of the post-Enlightenment absolutist state informed by the ideas of order, rationality and calmness that were considered necessary conditions for successful treatment. This approach also has its intellectual grounding in the biological tradition interpreting the adaptive responses of an organism to its environment – the tradition that elaborates on and to a certain degree complements the neurobiological approach to mental illness prevalent in this region. However distant, estranged and even contradictory the current conditions of the hospital are to this ideal – many wards in the hospital tend to breathe the therapeutic nihilism – this notion still remains a powerful ideal as well as an argument for the transformation of psychiatry. It is not only the physical but also the social environment that is of crucial importance for the potential recovery of patients.

This understanding of the role of the environment for improvement of the condition of patient has a resonance until now, as we can see on the example of the only recently built psychiatric hospital opened in 2009 in Hradec Králové under the directorship of Professor Jan Libiger. This relatively small facility – 60 beds – embodies the ideas that influenced the architecture of mental hospitals in late nineteenth century – set in a park, spacious and bright building – and its design was

inspired by similar hospitals built recently in the neighboring Bavaria.<sup>175</sup> The architect Jan Hochman in a dialogue with the psychiatrists designed a building that would allow plenty of natural light and subtle colours to create environment that in itself will have a therapeutic character. Professor Jan Libiger explains the ways in which the external environment affects the inner life of the patients:

“We need an environment would be safe for the patients and the staff and would not allow the patients to feel alienated and helpless and which might influence the atmosphere and assist in the healing process. The plan of the building is derived from the Vitruvian architectonic principles and the ideal proportions established by Da Vinci. I think the architect would say that this space indeed has a soul. The patients with mental illness need to spend more time in the hospital than those with physical illness, not only for the purpose of diagnostics and treatment, but also for the restoration of their inner equilibrium and gaining the distance from the stresses and problems in their lives. If we discharge depressive patient too early, maybe just after two weeks of treatment, very often they might be back in two weeks. Therefore we need to provide for those who need it the most and create alternatives for those who do not need to be treated in the hospital. We need to build a network of institutions which – in a sharp contrast to the asylum psychiatric hospitals of nineteenth century do not isolate patients but rather restore and return them to the society. With the current state of diagnostics and therapy psychiatry can treat mental disorders and wants to create conditions and endow the patient with strength to take control over their lives and use their talents and the potential of their lives as well as possible.”<sup>176</sup>

This quotation expresses some of the reasons driving the effort for the transformation of psychiatry and the improvement of the life conditions of the patients. The tension between this idealistic notion of a ‘therapeutic environment’ and the actual miserable conditions of the hospitals are one of the many paradoxes that define the theory and practice of psychiatry. Looking back at various reforms of care provided to patients suffering from mental illness – from the origins of hospital care, through the grand era of asylums, reforms in the 1950s and finally the endeavour to move away from institutional care to community care (which has been often criticized in countries that implemented this system) it seems like there is a

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<sup>175</sup> It is noteworthy that in the nineteenth century German physician Wilhelm Griesinger was advocating the idea of small asylums directly in the cities as part of general hospitals rather than the large rural asylums that became the winning concept of that time and only now becomes overruled in the form of recently build smaller municipal hospitals. See Rössler et al. 1994

<sup>176</sup> Interview with Jan Libiger in ZDN, 14.6.2011 <http://www.zdn.cz/rozhovory/predstavujeme/445794> and Libiger (2002)



tendency of gradual deterioration of care that makes further reforms necessary, irrespective of the actual forms of care. It is likely that the destructive force of mental illness as well as the social responses to people suffering from it contributes to this persistent tendency which has to be constantly counteracted.

The second theme that emerged from the previous discussion is the notion of curability. The distinction between conditions that are curable and those that are incurable has its material correlates in the institutional order of the hospitals which were originally conceived as separate institutions for those who had a hope for cure and those who did not – although currently patients of various courses of their conditions are treated in same hospitals yet often in separate wards. This tension between of what is curable and what remains as a permanent condition has significant implication for patient's self-understanding as well as the social response to their illness, in terms of stigmatisation, marginalisation and social exclusion.

In the perspective of many psychiatrists the stigma attached to mental illness is a reflection of the fear that they evoke as incurable conditions. They are convinced that once the currently incurable conditions become curable the stigma slowly disappears. The seclusion and isolation of people that suffer from these conditions become unnecessary once their condition becomes only temporary. They offer examples of leprosy, tuberculosis and even AIDS – conditions that once attracted similar social response as mental illness.<sup>177</sup> The perspective of recovery thus has significant implication for how the condition is perceived by the society (Lebowitz et Ahn 2012).

The hope that the knowledge gained from biomedical research shall eventually provide cure for conditions that are currently resistant to treatment drives the endeavour to extend the limits of science. If the right way to eradicate the stigma of mental illness is to transform the condition into temporary and transitory state from which the affected person can emerge fully recovered – and even prevent this condition from occurring by means of new therapeutic intervention based on

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<sup>177</sup> In France, for example, the psychiatric hospitals were located in vacated leprosariums – circumstances well known from Michel Foucault's work.

evidence gained from neurobiological research – then also the research itself is understood as an ethical imperative.

However, there is also another side of medicine as a science that necessarily treats its objects – or subjects – instrumentally. The anatomical dissection for which for centuries the unclaimed bodies of psychiatric patients were used represent a practice in which some of the motives addressed in the preceding chapters come together: the dissolution of human bonds as often experienced by psychiatric patients predisposes them to become an object of medical science; and the transformation of their incurable – impure – condition into medical knowledge that ultimately brings healing to others.

The third related theme is the notion of the soul. The neurobiological tradition with strong epistemological commitments to positivism and materialism – strengthened by the influence of Marxism – provides the intellectual background against which mental illness is understood and interpreted. The absence of the notion of that soul – an ancient cultural idiom that for centuries informed the understanding of mental illness – is contrasted with the patients' recourse to that notion in situations where they do not find the psychiatric interpretation of their experience plausible or satisfactory. This contrast seem to reflect the tension in approaching mental illness as medical and yet existential condition: there is a surplus of meaning that is left after the existential condition is reduced to the medical one. However instrumental and beneficial this reduction is for the treatment of their condition, the patients often turn to other resources to make sense of whatever is left unaddressed by the psychiatric interpretation of their experience and the realm of poetry, art and religion seem offers them a space and language through which they can more fully embrace their own situation.

In the final chapter the notion of the soul was addressed from yet another perspective: the soul as a defining feature of the humanity of the person. It was those considered to lack or have lost their humanity, their soul, who were deemed available objects for the sacrifice to science, and it is not a coincidence that often they were

patients suffering from mental illness. Their humanity was taken away – either while alive or after their death – by dissolution of the human relationships that could have granted them their dignity.

In one of the lectures I attended at the conference of social psychiatry Dr. Helena Klímová offered another interesting perspective on the disappearance of the concept of the soul from psychiatry. Based on several decades of her psychotherapeutic involvement with people who survived concentration camps as well as their family members, she observed how the restrictive and cruel conditions of the totalitarian regimes robbed people of their dignity as reflective and free persons by gradually marginalising them and degrading the relationships from which they derive their identity. Her thesis was that the essence of totalitarianism is the murder of the soul, the destruction of the individual as a subject. In many ways the psychiatric patients experience something very similar – being exposed to forces beyond their control where the destructive force of the illness reveals the existential nakedness of the human condition.

## **CONCLUSION**

## The Ethical Dimension of Psychiatry

*“After all these meetings [about transformation of psychiatry] led nowhere I started telling them: ‘you know what, this is nothing new. In recent European history we have had a health policy for psychiatric patients that was very cheap and functioned perfectly, do you know what I have in mind? It was perfectly simple and cost effective, and has been documented extensively, yes – the Holocaust. The murder of 300 000 schizophrenics and mentally ill – so you really do not need to work that hard on finding solution, if you want to save money and don’t really care that much how to do it, here is it...’ I know it is extreme that none will subscribe to today, but what we are seeing now is a slow process of the same kind and, honestly, it is actually not that different.”*

Jan Pfeiffer, interview 2008

In this thesis I have documented the situation of Czech psychiatry in the two decades following 1989 in its historical, cultural and political context. The persistent theme encountered in my research was the desire to transform psychiatry into a more ‘humane’ practice, into a more ‘humane’ place in which to find medical help and support for those suffering of mental illness. This motive was present in the interviews with my informants – medical doctors, lawyers, volunteers, family members, representatives of various NGOs as well as government officials and other professionals working with people whose lives were shaken by the experience of mental illness – and also in the historical resources I studied. The aim of the various initiatives that emerged since 1989 in the medical, cultural, and political realm, was to reestablish ethical relationships as the basis of social life and transform social institutions to accommodate this demand. The emphasis on solidarity as a core virtue of social life and the demand to extend moral community to include those who were previously marginalised and discriminated against was introduced by the Charter 77 movement and this emphasis also inspired and guided the initiatives in the early 1990’. I also described how the notion of solidarity was translated into the negotiations of responsibility between the representatives of the psychiatric

profession, various non-governmental organisations, and the representatives of the state, and how it resonated with to the international discourse on individual human rights which was used to promote and facilitate the transformation project. In the second part I have described the contemporary institutional practices of dealing with persons suffering from severe form in mental illness, as well as the historical approaches that are manifest in the material culture and the various forms of medical knowledge. The liminal status of patients living in psychiatric hospitals while losing or being stripped of their humane characteristics is counterweighted by the interventions aimed to cure, rescue and redeem the patients from their conditions.

I have also observed that although in the interviews and documents the adjective ‘humane’ was often used it was never considered necessary to explicitly specify what is actually meant by this denotation. The political anthropologist Talal Asad notes that the notion of the humane is complex and often contradictory. He writes:

“Attention to the content of the idea of humanity, to the language expressing desire and affect when talking about humans, and the political reasoning used variously to demand their liberation or improvement, their protection or sacrifice, indicates how complicated the process of recognizing humanity is. ... The idea of difference is built into the concept of the human.” (Asad, Critical Enquiry)

In the narratives of my informants, the notion of ‘humane’ or ‘human’ was similarly often contrasted with its apparent opposites: inhumane conditions, inhumane treatment, animal-like states. The motive of improvement, cure, and redemption was very much present in the narratives of my informants in recollections of their personal experiences. Also, it permeated the convictions expressed by some of them that the transformation of society can be achieved through the extension of the ‘humane’ to those who on various grounds are considered not entirely ‘human’, or who are reduced into de-personified objects of medical intervention and subject to ‘inhumane’ institutional and bureaucratic practices, or in extreme form, annihilated. Talal Asad observes that the concept of the ‘humane’ carries traces of the Christian idea of redemption: *“Reaching out compassionately to another’s pain (or sin) not only redeems individuals who are*

*endangered but also elevates humanity as a whole*” (Assad, Critical Enquiry).

Although secularized in the post-socialist context, this motive was very much present in the context I describe in my thesis. I was hoping to capture and examine the tensions created by these two contrasting movements. There is an inevitable tendency to reduce the Other and remain indifferent to their suffering which clashes with – but is also constitutive of – the initiatives to counteract this tendency. These initiatives thus reveal and make justice to the inherently ethical dimension of human encounters.

In order to bring the various themes and ideas in this thesis together I will draw on the work of Emmanuel Lévinas (1907-1995) whose theoretical perspective has significantly informed and shaped my own understanding of ethics. In his major work *Totalité et Infini* Levinas presents offers a powerful critique of the traditional way of understanding ethics as secondary to and derived from ontology (Totality and Infinity, 1961). This perspective allows for understanding ethics as prior to ontology which includes both the sphere of science and politics. As I will show, his approach helps us understand that the reductionist tendencies of social institutions, be it in medicine – where the suffering Other becomes the patient – or in the political sphere – where the Other becomes an object of various state policies – need to be constantly transformed by personal encounters that reveal the inherently present ethical moment. I will briefly outline some of the main aspects of his thought as articulated in *Totality and Infinity*, especially the rearrangement of the relationship between ethics, metaphysics and ontology, contemplate the possible implications of this approach, and finally interpret the situation described in my thesis in Lévinasian terms.

The introduction to the *Totality and Infinity* (Lévinas 1991, Preface) begins with the notion of war, which is understood as a paradigmatic situation of violence that none can distance from, to which nothing can be exterior. He writes:

“But violence does not consist so much in injuring and annihilating persons as in interrupting their continuity, making them play roles in which they no longer

recognize themselves, making them betray not only commitments but their own substance, making them carry out actions that will destroy every possibility of action” (p. 21)

The face of Being presenting itself in the war is expressed in the concept of totality. His claim is that the concept of totality dominates Western philosophy: reducing individuals to subjects of forces beyond their consciousness and control. The meaning of individuals is derived from this totality, and the uniqueness of the present is sacrificed to a future which would show their objective meaning, i.e. history. The image and experience of war and totality is representative of not only war and violence as such but as other forms of experience where the uniqueness of the individual is reduced to an objectified entity, such as the sphere of knowledge and the sphere of politics. Knowledge denies the uniqueness of the Other by neutralizing otherness in generalizing concepts which can be grasped and understood – thus reducing the Other to the Same. That is the sphere of science, with its denial of uniqueness for the sake of the universal. Another mode of denying the Other is in possession and power, the sphere of politics and social institutions.

However, there is something that reaches beyond this totality and is reflected in human history. This is the experience of subjectivity and responsibility in relating to the Other. In *Totality and Infinity* Lévinas develops a phenomenology of the face, the primary relationship to the Other. The manifestation of the Other in the face constitutes the ethical relationship of responsibility. Face-to-face is the primordial situation where the Other presents as a demand, a call for response:

“The face in the nakedness as a face presents to me the destitution of the poor one and the stranger; but this poverty and exile which appeal to my powers, address me, do not deliver themselves over to the powers as given, remain the expression of the face. The poor one, the stranger, presents himself as an equal” (Lévinas 1991, p. 213).

Lévinas thus grounds the most fundamental ethical command in the face-to-face encounter. The Other for Lévinas is always someone in need, a stranger. In one of the interviews he formulates it in the following way:



“There is first the very uprightness of the face, its upright exposure, without defense. The skin of the face is that which stays most naked, most destitute. There is an essential poverty in the face; the proof of this is that one tries to mask this poverty by putting on poses, by taking on a countenance. The face is exposed, menaced, as if inviting us to an act of violence. At the same time, the face is what forbids us to kill.” (Levinas 1985, p.86)

The face, which both reveals and hides, is the embodiment of Otherness. The face addresses our egoism and challenges us to respond, the response being the responsibility for the Other. For Lévinas this responsibility is the essential, primary and fundamental structure of subjectivity. The face limits my freedom, saying: thou shall not kill. Murder is an effort of absolute negation. However, there is always something which resists this negation and that is the Otherness which cannot be destroyed or annihilated by any such means. Even if I kill, the Other remains, never fully subordinated or reduced to my will. The Other can never be fully comprehended and remains forever distant. Because of this radical Otherness the relationship with the Other also opens up the space of infinity, of transcendence, of the ethical.

The face presents itself as a demand not to remain indifferent to the suffering of the Other, as suffering is the proximity of death. Lévinas writes:

“In pain, sorrow, and suffering, we once again find, in a state of purity, the finality that constitutes the tragedy of solitude. The ecstasis of enjoyment does not succeed in surmounting this finality. ... The content of suffering merges with the impossibility of detaching oneself from suffering. In suffering there is an absence of all refuge. The way death has of announcing itself in suffering, outside all light, is an experience of the passivity of the subject” (Lévinas 1987, p. 68, 70).

Exposed to death, the face of the Other also signifies ‘do not leave me alone in my death’ (Lévinas 2002, p.145). For Lévinas this is the ethical grounding of medicine:

“Original opening toward merciful care, the point at which – though a demand for analgesia, more pressing, more urgent, in the groan, than a demand for consolation or the postponement of death – the anthropological category of the medical, a category that is primordial, irreducible and ethical, imposes itself. For pure suffering, which is intrinsically senseless and condemned to itself with no way out, a beyond appears in

the form of the interhuman. The interhuman lies in a non-difference to one another, in a responsibility for one another.” (Lévinas 2006, p.80, 86)

The ‘interhuman’ here is thus constitutive of the ‘human’.

Medicine often considers death as a failure of cure, the ultimate limit of medicine. However, for Lévinas, situations where the conditions are incurable, technologies fail and medicine is left with its only ‘instrument’ – human presence – reveal medicine’s original ethical grounding. It is a demand not to leave patients alone in their death. In acknowledging the moral imperative of the face, suffering is transformed and the space of transcendence opens – not a transcendence in a metaphysical sense but rather in being concerned more with the suffering and death of the Other prior to the concern with one’s own demise. This is also the meaning of ‘humanity’ that Lévinas calls goodness: *“Goodness consists in taking up a position in being such that the Other counts more than myself. Goodness thus involves the possibility for the I that is exposed to the alienation of its powers by death not to be for death.”* (Lévinas 2002, p. 247) The concern for the death of the Other thus comes before the care for the self or concern for one own’s death. Lévinas does not present any form of theodicy, and for him suffering – the evil of suffering – remains intrinsically useless, ‘for nothing’. The only way suffering can gain meaning is when it becomes suffering for the suffering of someone else. Lévinas writes:

“It is this attention to the suffering of the Other that can be affirmed as the very nexus of human subjectivity, to the point of being raised to the level of supreme ethical principle – the only one it is impossible to question – shaping the hopes and commanding the practical discipline of vast human groups.” (Lévinas 2006, p.81)

Ethics is in this perspective a relationship with the Other, the desire of Infinity. Subjectivity as a space of hospitality resists the totality of history and political institutions. The ethical is a space of both interiority – subjectivity that is able to welcome the Other – and exteriority – in the infinite transcendence of the Other – that breaks through the totality of the system. Ethics is the possibility of transcendence, of relationship with Other without subjecting him to the order of

need, knowledge or power. Ethics is thus understood as a nonviolent relationship to the Infinite as infinitely Other, as metaphysics (Derrida 1997). From this perspective, history can be interpreted as the interplay between the totality and the flashes of the Infinite in the encounters with the Other.

For Lévinas, the notions of totality and infinity also constitute the distinction between morality and ethics. Morality is part of totality and is dependent on and derived from its orders. Morality is impersonal and refers to the universal principles – justice and rights – ethics by contrast is always personal – love and hospitality.<sup>178</sup> On one hand this acknowledges the relativity of any moral system, on the other it makes the responsibility for the Other absolute. Ethics then cannot be understood as a set of principles or laws which would still be part of totality, contingent on historical and cultural circumstances. Ethics nevertheless inform the concept of justice that for Lévinas still originates in the encounter with the Other. It is the multiplicity of men and the presence of someone else next to the Other which conditions the law and constitutes justice. He formulates it like this:

“If I am alone with the Other, I owe him everything; but there is someone else. ... The interpersonal relation I establish with the Other, I must also establish with other men; there is thus a necessity to moderate this privilege of the Other; from whence comes justice. Justice, exercised through institutions, which are inevitable, must always be held in check by the initial interpersonal relation.” (Lévinas 1985, p. 90).

In this sense the encounter with the Other presents as a demand to aim for justice on their behalf, to be concerned about the injustice done to them. *“In reality, justice does not include me in the equilibrium of its universality; justice summons me to go beyond the straight line of justice.”* (Lévinas 1991, 245) The concept of ethical justice then informs the concept of formal justice developed within the framework of

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<sup>178</sup> This is very similar to other conception in Judaism, as tzedakah and mishpat (charity – righteousness and justice) and hessed and rahamim (loving kindness – love and compassion) (Sacks 2005: 44-56) and of the concepts of contract and covenant (Newman 1991). The thought of Emmanuel Lévinas is essentially embedded in two worlds: European philosophy stemming from the ancient Greek philosophy on one side, and the biblical and talmudic tradition of Judaism on the other. Therefore, his work has often been understood as the Septuagint project, i.e., translating of Jewish thinking to the world of Greeks (Ofra 2001:133).

social institutions of the state which also allow for its legitimacy and accountability.

As one of his interpreters formulates it:

“Lévinas’ insistence on my infinite responsibility for the Other therefore does not merely imply the impossibility of meeting my responsibility. Rather, infinite responsibility functions as a measure of legitimacy for every social, economic, and political arrangement in every state. Accepting ethics as the first politics means that for-the-Other should ground the constitution of the State. (Tahmasebi-Birgani 2014, p. 33).

It is this ethical moment revealed in the encounter with the Other and testified to by the endeavour to bring about justice that I have aimed to capture in this thesis in the multiplicity of situations and events that have shaped the practice of psychiatry since 1989. The tendency to reduce the Other into an object of intervention of medical practice and subject them to the bureaucratic order of state policies is a persistent and possibly inevitable characteristic. However, the reminders of the irreducibility of the Other are equally present in the personal encounters that are at the core of social and political life. The first half of the thesis aimed to portray the various forms in which this initial ethical impulse has been translated into the practices of treatment of people who were devastated by illness and marginalised in society. The break with the totalitarian regime provided an opportunity to transform social institutions to conform to the ethical demand. There were several initiatives in psychiatry which saw the change of the regime as an opportunity to transform the way care for those with severe mental illness was provided, to be more attentive to their needs and taking them seriously as persons. These were taken forward in several different directions as the project of ‘humanization of psychiatry’ and I described them in the first three chapters. The intellectual orientation of Charter 77 that resonated in this project was influenced by phenomenological and existentialist philosophy where human vulnerability and illness represent an inherent possibility of the human condition – rather than its pathology. The experience of shakiness in the taken for granted certainties of life was considered to be the source of human solidarity.

Almost as a counterpoint to many political theories – including liberal, libertarian as well as social contract theories – that take as their point of departure the sovereign, rational, autonomous subject, in this perspective it is human vulnerability that becomes the defining feature of our being in the world and the foundation of political responsibility. The acts of others thus redeem the dignity of the individual person: the endeavour for mercy and justice is constitutive of human community. The discourse of human rights aimed to capture the motives of rectification and redemption in a secularized version and its employment might be considered the pragmatic attempt to transfer the initial ethical moment into the political order and thereby break through the totality through the transcendence immanent in the relationship of responsibility towards others. However, this initial ethical moment has slowly been obscured by more pressing agendas of economical transformation, professional establishment, and retrospectively has been considered naive and even laughable by the current political representation and public opinion. Despite this, I continue to consider these initiatives important and worthwhile. It has been interesting to explore the motivations and meaning with which the actors endowed the whole project although these are not necessarily evident in the actual outcomes. They represent an aspiration to make justice to the humanity of the Other, however transformed and disfigured by illness and misery.

In the second part of my thesis I described how the ideals of cure and redemption from illness play out in material culture as well as in the ordinary interactions of people in hospitals. Again, the tendencies to objectify the patient and subject them to the indifferent institutional order are sometimes counteracted by the return to the ethical dimension of the human encounter that grounds and justifies medicine as a social practice. I introduced medicine and psychiatry as the interplay of the tradition of care and the tradition of knowledge. The tradition of scientific knowledge can be traced to the Greek notion of knowledge as *theoreia*, *praxis* and *techné*. Knowledge is in this context understood as a metaphor of light, seeing, grasping and handling, and both science and technology belong to this sphere. In

medicine, the theoretical and instrumental concepts are necessarily based on reduction, generalization and denial of uniqueness. For Lévinas, however, this is part of the great ontology project in which the being is subjected to the rule of One and Same and is therefore violence. However, knowledge about the Other and their situation still might be transformed to understanding their condition in order to effectively respond to their needs.

The tradition of care is one of the constants of culture. It is often said that the values of society are reflected in the way the most vulnerable people are treated. This is much more straightforward in small-scale societies based on personal relationships than in the large-scale institutionalized societies (*Gemeinschaft* and *Gesellschaft* as in Tönnies 2005). In the community the immediate presence of the Other is very clear and this creates the space for ethical relationship as such. However, the institutionalized societies order have to rely on systems of morality, both implicit in everyday encounters with strangers, role-based and impersonal relations, and explicit as in the legal code that depends on shared ideas of morality. Many of the people I encountered in the hospitals lost or never had the ties of kinship and immediate community and were therefore entirely dependent on the institutional structures. Medical care is institutionalized and provided by state and as such belongs to the sphere of politics and its practice is subjected to law. Nevertheless, it can never be entirely impersonal as care presupposes personal engagement with the Other. The humiliation, indifference and neglect that some patients experience is as possible as genuine concern guided by ideals of hospitality, compassion and love. Genuine concern for the Other may redeem the Other from the totality of the political order, from the institutional indifference.

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## **LIST OF FIGURES AND PHOTOGRAPHS**

## **APPENDICES**

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## **APPENDIX 1**

### **RESEARCH METHODOLOGY – DETAILS**

## **I. Archive and Library research**

## **II. Ethnography in the Hospitals**

- Research Sites and Access
- Ethics Committee Approval
- Prague Psychiatric Centre
- Kosmonosy Hospital
- The Art Festivals

## **III. Additional Interviews with Psychiatrists, NGOs and Government Representatives**

- Ministry of Health
- Psychiatric Association
- Psychiatrists
- Human Rights Initiatives – Government and NGO
- Patients' Organisations

## **I. Library and Archive Research**

The first three months of my research (October – December 2006) I spent reviewing literature on the history of psychiatry in Czechoslovakia and other Eastern European regions, including the legal framework for psychiatric practice. This research provided me with the contextual understanding of the phenomena I encountered in my fieldwork and enabled me to identify and refine some of the themes I followed in my research. The literature review also informed subsequent interviews both in terms of choice of informants and the range of topics that I found interesting and worthy of further examination. I continued to consult these sources in the course of my fieldwork

One of the sources for the early forms of mental health care in this region were 'anniversary books' of various psychiatric hospitals published recapitulating their history on the occasion of their centenary jubilee which were illuminating for understanding the historical context of institutional care. One of the psychiatry professor and amateur historian, Eugen Vencovský, published several books on history of psychiatry which in addition to being informative were also interesting for understanding the self-presentation of psychiatric profession. I also studied textbooks and periodicals from the post-war period, as well as conference volumes from various professionals meetings in the countries of Eastern Europe.

Two publications on Czechoslovakian psychiatry appeared in English. The first of them is Ari Kiev's edited volume *Psychiatry in the Communist World* (1968), a collection of essays on the state of psychiatry and mental health care written by psychiatrists from countries of Eastern Europe, Russia and China. Although it is



challenging to retrospectively distinguish objective reports from ideological propaganda with which they are embedded, it is nevertheless very interesting historical document.

Another volume edited by US and Czech scholars Richard M. Scheffler and Martin Potůček, *Mental Health Care Reform In the Czech and Slovak Republics, 1989 to the Present*, was published shortly after I completed my fieldwork in 2008 in Prague as a result of five year collaboration. It is authored by psychiatrists and social scientist from Czech and Slovak Republic and offers thorough overview of many aspects of mental health care. With some historical distance might be also seen as a testimony to the re-orientation of this region from the East to West, where the process of deinstitutionalization serves as a referential point.

Most of my library research was conducted in the National Library in Prague in Klementinum (which holds copies of all books and journals published in Czechoslovakia) Medical Library in Prague, Library of the History of Medicine Institute at the Charles University, with occasional visits to the archives of hospitals in Bohnice and Kosmonosy. Thanks to my fellowship at UCL I also greatly benefited from access to the library of School of Slavonic and East European Studies and the Wellcome Library.

## **II. Ethnography in the hospitals**

### **Research Sites and Access**

The choice of the two psychiatric hospitals in which I conducted my fieldwork was determined by several factors, some strategic and some practical. I was aiming to capture the contrast between acute and long-term care and therefore I have chosen university hospital in Prague and a psychiatric sanatorium outside of Prague. Prague Psychiatric Center is affiliated with medical school I was working for at that time (as a lecturer in ethics) and where I myself trained, and with which I was therefore already familiar and was able to negotiate access easily. Prague Psychiatric Center<sup>179</sup> is institutionally independent of but set on the premises of the largest psychiatric hospital (sanatorium, with 1200 beds) in Prague Bohnice.<sup>180</sup> My colleague at the university and director of the Public Health Department, Dr. David Marx, offered to arrange access to the Kosmonosy hospital.<sup>181</sup> This hospital is about 60km north from Prague and was among the first hospital build outside of Prague for the purposes of care for ‘incurable patients’. In addition to acute wards for patients from the district catchment area, the majority of its capacity consists of chronic wards, geriatric wards for elderly psychiatric patients, patients with combined developmental (severe learning disabilities) and psychiatric disorder, disorders of sexuality, and forensic wards. With its 600 patients it belongs among the smallest of

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<sup>179</sup> <http://www.pcp.lf3.cuni.cz/pcpout/>

<sup>180</sup> <http://www.plbohnice.cz/>

<sup>181</sup> <http://www.plkosmonosy.cz/>

the sanatoria type hospital, which could have up to 2000 patients in the past . The director of the hospital and the medical director were very helpful in negotiating my access.

My formal position in these two places was different. While in Prague Psychiatric Hospital I was officially a researcher, in Kosmonosy hospital for administrative purposes I was a psychiatric trainee – without any responsibility for patient's care, but still clearly identifiable as a medical doctor by the virtue of having to wear a white coat and a name tag indicating that I am medical doctor. This also had implications for the ways in which I spent my time in the hospitals. In Prague hospital I spent most of my time with medical students, observing them in lectures and in practical training on the wards, and my interaction with patients was mostly indirect through observation of their interactions with medical students and physicians, and in arranged interviews with some of them. In Kosmonosy hospital I formally was appointed as a physician in training (honorary contract) and the patients related to me in this way as well. This is another reason – in addition to the ambiguous research ethics approval – why I did not include any personal narratives from the thesis. Although I always asked for permission to be present and explaining my research interest to the patients, their trust in me was attributable to my medical status.

In the course of my fieldwork in these hospitals I had the opportunity for many informal conversations with patients, carers, and psychiatrists. I also conducted semi-structured interviews with physicians, nurses, social workers and psychologists working in these hospitals.

### **Ethics Committee Approval**

In order to conduct fieldwork in these hospitals I submitted my research proposal to the Ethics Committee of both institutions.

In the Prague Psychiatric Center this is a standard formalized procedure. After submitting the description of my research and forms of informed consent and other documents in advance to the ethics committee and being granted permission to conduct research under the condition that I shall obtain written consent from all research participants – patients, physicians, and medical students. My presence in these settings was however more 'invisible', I mixed up with students and participated on their training, and I did not encounter any issues with obtaining these from any of the participants. In addition to being present to teaching sessions where of which interviews with patients were part of I was also able to interview several patients in length.

In the Kosmonosy hospital I also submitted all necessary documents for approval by the Ethics Committee several months before the commencement of my internship. However, when I came for the first day of my research and asked about the Ethics Committee permission I was informed that they did not consider it necessary to have to approve my research, given the nature of my interests, and the fact that I am trained as medical doctor. I was allowed to participate in any kind of

activities I wish to and visit any wards in the hospital with the permission of the psychiatrist responsible for that ward. I was informed that asking patients for permission was considered inappropriate and potentially disturbing since it might just confuse them, and it was considered enough if I wear my white coat indicating my trainee role, and upheld the ethical standards of a medical professional. This turned out to be both an advantage and limitation of my research. The informality of my presence enabled me to participate in various activities and visit different parts of the hospital, but it also posed a serious challenge as to whether I can actually use this information since I do not have a written permission from each individual participant. I have always introduced myself to patients as a psychiatrist-researcher, asked for permission to be present and – granting the anonymity – to use the data for my research. Given the nature of the institutions where many patients feel lonely and isolated, most of the patients and staff were actually eager to talk to me and have me attend to the various consultations and activities they participated on.

### **Prague Psychiatric Center**

The activities of the Prague Psychiatric Centre are developed in three main directions: scientific research in the area of neurobiology and psychiatry; clinical work; and pre- and post-graduate training in Psychiatry.

Clinical part of the Centre consist of three inpatient wards with 60 beds in total and it considered a highly elite facility. The wards are divided according to the main groups of mental disorders: anxiety disorders, affective disorders and psychoses. The wards differ in regime – first two of them have open-doors regime, the third one is a closed ward – and therapies offered (pharmacotherapy, psychotherapy, art therapy, work therapy, balneotherapy, patient education and preventive approaches). There are also three day hospitals designed and run by the doctors, and an outpatient clinic for follow-up patients after discharge. This hospital (unlike all others) does not have any catchment area and patients are referred here by their physicians or the transfer from other hospital is arranged by their family.

There is around 30 medical doctors working as clinicians, most of which also conduct research. There is also a number of PhD students and researches with non-medical background (psychology, biology, computer science etc.). In addition to basic research in genetics, imaging methods, electrophysiology, epidemiology, psychopharmacology funded by government agencies and in collaboration with international partners (USA, UK, Germany, WHO), multiple clinical studies sponsored by pharmaceutical companies are conducted here. This collaboration is seen as beneficial since as a form of reciprocity, these pharmaceutical companies sponsor other projects of the Centre for which no other resources would be available (such as expensive medication, patient education and prevention programs).

The Centre is a teaching hospital for the Third Faculty of Medicine of the Charles University in Prague, both in pre-graduate and postgraduate medical training and in nursing. The undergraduate teaching in psychiatry takes place in year 3, 4, and 5 of the six years medical curriculum.

The first introduction to Psychiatry is in year 3 as a part of 'Clinical Propedeutics', where the principles of clinical examination and evaluation are introduced, as well as the specification of challenges that the interaction with mentally ill patient might pose (14 hours). In year 4, students complete relatively extensive course in Medical Psychology and Psychopathology (45 hours) where the basic concepts of psychopathology are introduced, and a core course called Mental Disorder (100 hours). This is followed by the final course in Psychiatry in year 5 (50 hours). In addition, there is also a session on Ethics, with seminars on the use and misuse of psychiatry, involuntary treatment and the use of restraints. Students might also chose to attend elective courses ranging from introduction to psychotherapy to biological psychiatry and are offered to participate on various research projects. All students have to pass final oral state exam in Neuroscience, where Psychiatry is examined together with Neurology and Psychology by a committee consisting of four professors. This state exam is unique among medical schools in the Czech Republic and in comparison to other medical schools (there are 7 of them in the CR) this one has the highest number of teaching hours devoted to psychiatry.<sup>182</sup> Among the graduates there is also significantly higher number of those who choose Psychiatry as their specialty, which is generally attributed to excellence in teaching, enthusiasm of clinical teachers and researchers and generally pleasant atmosphere in this hospital.

The psychiatry teaching is organised in blocks lasting several weeks which enabled me to attend all the lectures and practical training, some of which I attended on several occasions with different group of students (the teaching occurs both in Czech and in English for international students). I chose to focus on the teaching of psychiatry to medical students in order to gain insights and understanding of the transmission of knowledge and its enactment in clinical practice. In the course of their training students undergo a process of transformation from strangers to this field of enquiry to mastering the knowledge and skills necessary to interview and examine the patient, judge on their potential psychopathology, propose diagnostic and therapeutic plan, write up a complex report.

In year 3 the students do not always meet patients although part of the seminar is presentation of video recording of interviews with patients by doctors. In year 4, the course is organized around ICD diagnoses, so that each day one group of psychopathology is presented with focus on diagnostic process, followed by an interview with patients who volunteer to come to the lecture hall. In the beginning of the course the patients are interviewed by doctors and students are invited to participate by posing additional questions, while later in the course the students themselves are expected to interview the patient. This presentation of patients is followed by the discussion of patients history and symptomatology, diagnosis, and treatment options. In year 5, students are divided into small groups and spend the mornings on the wards (circulating all three wards in the course of two weeks), following the work of individual doctors. This is followed by a seminar that on

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<sup>182</sup> The other state exam subjects are Internal Medicine, Surgery, Gynaecology and Obstetrics, Paediatrics, and Preventive Medicine.

therapy and treatment, again structured around ICD. In the last three days of their internship the students are allocated a patient for interview and examination and are based on this interview they write complex report that they present as a part of the state exam in Neuroscience.

I have attended each of the courses during the one year of my fieldwork with different groups of students (those currently in year 3, 4, and 5, both English- and Czech-speaking), and was able to attend and sometimes to record their formal teaching as well as informal conversations. In all cases where patients were involved I secured their written permission to be present and use the data for the purposes of my research.

### **Kosmonosy Hospital**

This hospital consists of 17 separate wards, taking care of over 600 hundred patients. Most of the wards – and actually whole buildings – are either male or female, and are further differentiated by age and the nature of the condition. There are four admission wards (male/female, general/geriatric), intensive care unit, forensic ward, sexual disorder ward, wards for combined mental retardation and psychiatric disorder, geriatric wards, addiction wards, and rehabilitation ward. This hospital has also additional facilities in a nearby village for psychosocial rehabilitation of recently discharged patients. There are also several workshops, garden, library, and a riding hall, for the purposes of therapy.

There are around twenty psychiatrists working in the hospital, most of them appointed permanently to supervise specific wards, with the exception of doctors in training who help wherever they are needed. One of the doctors was very kind to act as a supervisor during these two month, and her ward – admission female ward – became the primary site of my research. As I got to know other physicians, psychologists, and a social workers whom I followed in their various tasks in different parts of the hospital throughout the day. This enabled me to spend some time in most of the wards and become more familiar with the life of the institutions. I have also learned a lot about the collaboration with other institutions – different hospitals, community centers, out-patient specialist – which provided me with additional insights to the needs of the patients and the challenges they face. Since few other doctors and psychologists commuted from Prague every day I was often on the same bus or car, and the conversations on these informal occasions – as well as coffee breaks and lunches – were indispensable sources of insight into nature of their work.

My research followed the rhythm of life in this institution: starting at 7am, I followed psychiatrists, psychologists, nurses and social workers on their ward rounds, where they talked shortly with each individual patient, reporting on what has changed since previous day, and discussing the future plans. After the ward round I spent some time in the doctor's and nurse's offices, observed them writing reports and discussing individual patients, administering medication, and administrative activities. This was followed by coffee break – while patients had their breakfast –

where physicians discussed the course of treatment of individual patients, with their names written on a blackboard where the notes were also taken. Around 9am patients and staff would gather in a common room for what is called 'a community'. This is partially informal session where issues of previous days are discussed and the day ahead planned, with options to spend time in the library, art workshop, occupational therapy, individual therapy, or just resting or helping nurses with some paper work. After lunch some of the patients were allowed for walk with a nurse or on their own, depending on their condition.

In the course of the day I was sometimes following individual physicians with their work, sometimes spending time with psychologists, nurses, or the social worker in their various tasks. Sometimes I volunteered for the social worker to do her shopping in the local grocery store to buy some basic necessities for patients (toilet paper, chocolate, toothbrush...). I also attended occupational, art therapy and hippotherapy sessions led by nurses and therapists. I often spent time on some of the wards chatting with individual patients – some of whom soon considered me their 'friend' and expect me to come and see them every day.

The material condition of the hospital are rather impoverished (as evident from the pictures) and the patients also live with a bare minimum of what they need – several basic pieces of clothes and hygienic products, sometimes a pen and a paper. However, there are several scarce objects that have great value for patients and around which the informal domestic economy evolves. Among these precious objects are cigarettes and coffee, chocolate and toilet paper, and I observed how these are obtained, exchanged, and how relationships are constituted by their ownership and exchange. There is very little privacy (rooms are shared by four to sixteen patients) and it was interesting to observe how some patients try to protect their individuality and create their own space, while others seem to be completely indifferent to the presence of others. I was trying to understand what friendship means in these places and how the patients relate to the outer world, represented by occasional visits of relatives or friends, and excursions behind the hospital walls.

### **The Art Festivals**

The omnipresence of art in psychiatric hospitals, workshops, and art festivals on the premises of the hospital led me to examine closer these activities and the role of art in therapy, the exchange of objects produced in therapy, the creation of community on a ground of artistic activities. In fact, the essential part most of the psychiatric hospitals built in late nineteenth century was not only a church, but also a theatre and exhibition hall, which indicates significant role of art even in that time. While still in medical school we held annual performance of our theatre company in the Bohnice theater, and every Christmas also organized a concert in the Prague Psychiatric Center. I realized that art has a role both as a means of communication in the art therapy session, and as a platform for social encounters through various art festivals.

In 1990, the first art festival was hosted on the premises of psychiatric hospital in Prague, Bohnice, as one of the initiatives of the Week for Mental Health. It soon gained wide popularity, and twice a year there is a festival of music and theatre, accompanied by exhibitions and various workshops – *Babí léto*<sup>183</sup> [Indian Summer] in the autumn, and *Mezi ploty*<sup>184</sup> [Within the Fences] in late spring. There is a strong symbolic undertone to these initiatives and this event is attended by around 30 000 people every year. The intention of these events is to ‘break down the wall between two worlds’, and ‘de-stigmatize’ mental illness, and the admission fee supports art therapy in the hospital. This initiative of artists and psychiatrists has spread to other psychiatric hospitals, most of which now host similar events every year. Kosmonosy hospital hosts the festival *Na Kopečku*<sup>185</sup> [On the Hill] in late summer.

Art and occupational therapy is also indispensable part of the filling of time in the hospitals. These sessions create an environment where many interesting conversations take place. As it provides a space outside the wards, patients often seem more relaxed and enjoy the opportunity to create something new and chat with other patients. Hospitals have different workshops – mostly ceramics, textiles, woodwork – where patients can work, and the community care centers also have established these. There is usually a small shop in the hospital as well as several in the towns that sell their products, and where patients work as part of their psycho-social rehabilitation.

### **III. Additional Interviews with Psychiatrists, NGOs and Government Representatives**

I have interviewed several professionals working in psychiatry and mental health care in order to understand the wider situation and debate around the transformation of psychiatry. I was hoping to capture perspective of wide range of individuals and institutions involved in this area – psychiatrists and other professionals working in different settings, representatives of government bodies and non-government organisations. These are specified in Figure 2.

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<sup>183</sup> <http://www.unijazz.cz/cs/babi-leto-bohnice/9/>

<sup>184</sup> <http://www.meziploky.cz/cs/>

<sup>185</sup> [http://www.volny.cz/festival\\_na\\_kopecku/](http://www.volny.cz/festival_na_kopecku/)

Figure 1 - Institutions / Organisations / Interviews and Resources

<b>Ministry of Health</b> <a href="#">EMAIL, REPORT</a> Tomáš Vyhnanek	<b>Ministry of Labour and Social Affairs</b>	<b>Ministry of Human Rights and Minorities (2007-2010)</b>
<b>Czech Psychiatric Society</b> Pavel Baudiš, Zdeněk Bašný	<b>Government Council for People with Disabilities (est. 1991)</b>	<b>Government Council for Human Rights (est. 1998)</b>
<b>Hospitals and Sanatoria</b> Ivan David, Zdeněk Bašný, Jiří Bazika, Iva Tlášková, Filip Španiel, Lucie Motlová, David Holub		*Committee against Torture and Inhuman Treatment Lucie Rybová
<b>Community Services</b> Ondřejov (est. 1984) Martin Jarolimek		*Committee for Human Rights and Biomedicine Pavel Baudiš
BONA (est. 1992, 1999) Zdeněk Bašný		<b>Government Commissioner for Human Rights (est. 1998)</b> Jan Jařab
Fokus (est. 1990) Jan Stuchlík, Alena Fialová		<b>Public Defender of Rights (2001)</b> elected by Chamber of Deputies of the Czech Parliament <a href="#">EMAIL, REPORT - audit on human rights in psychiatric hospitals 2007</a>
ESET (est. 1995) Ondřej Pěč		
Center for Mental Health Care Development (est. 1995) Jan Pfeiffer, Jan Stuchlík		League for Human Rights (2002) Mental Disability Advocacy Center (2002) (represented in the Committee for Human Rights and Biomedicine) <a href="#">REPORTS</a>
Czech Association for Mental Health (est. 1996) Lucie Rybová, Martin Jarolimek		
Kolumbus Lucie Rybová		

Figure 2 – Institutions / Organisations / Interviews and Resources

There are three government resorts that are directly involved with the agenda related to psychiatric care – *Ministry of Health*<sup>186</sup> responsible for health care policy (and also directly responsible for majority of psychiatric hospitals as its ‘founder’); *Ministry of Labour and Social Affairs* responsible for policy on social care (and which also provides grants for many of the non-governmental organization providing community care); and the government resort of *Human Rights*, consisting of the *Office of the Commissioner for Human Rights* (which for a period of time was also a Minister for Human Rights), the *Government Council of Human Rights*, as well as the independent *Office of Public Defender of Human Rights* (which is a Parliament appointed body).

The non-governmental and professional bodies concerned with psychiatric care could analogically be divided into three areas – professional bodies representing health care professionals of which most of my physician-informants are active members (Czech Psychiatric Society); organizations and institutions in the intersection of health and social care (mostly providers of community care services); and human rights advocacy groups (often with ties to international organizations).

<sup>186</sup> <http://www.mzcr.cz/>



## **The Ministry of Health**

The Ministry of health is responsible for healthcare in the Czech Republic and therefore I approached it with questions regarding mental health care policy. However, there is none in the Ministry responsible for the mental health care (most of the EU countries have separate departments responsible for mental health policy), and most of my attempts to gain any information regarding transformation of psychiatry proved futile, on one occasion I was recommended to contact the Czech Psychiatric Association for any information<sup>187</sup>. Given the non-existence of this issue on the political agenda the current situation is less surprising. In addition, the Ministry of Health has been the most unstable seat in the Government, the position of the minister was held by fifteen different officers in the course of 20 years, and their major priority was the economic transformation of healthcare (introduction of healthcare insurance and privatization of health care providers).<sup>188</sup>

## **Psychiatric Association**

The Czech Psychiatric Society is a professional association and one of the Societies forming the Czech Medical Association of Jan Evangelista Purkyně. I attended several conferences organized by this association, including one on legislation in psychiatry with debate over the proposal of Mental Health Act, and a conference of the society is Social Psychiatry section.

The Czech Psychiatric Society also represents interests of the profession to the Ministry of Health and acts as its advisory body for issues related mental health policy. This society was a platform for discussion on the transformation of psychiatric care since 1990s, and issued two versions of the 'Proposal for Transformation of Czech Psychiatry' (1996, 2008). Despite my attempts I was unable to interview some of the consortium members who were too busy to have time for interview (some did not respond my email at all). However, several of my informants (Dr. Pavel Baudiš, Dr. Zdeněk Bašný) have been serving on the board in different periods of time and others were initiators and co-authors of the Proposal.

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<sup>187</sup> Several emails remained unanswered, and the only response I got is from July 2008 by Dr. Helena Sajdlová, director of the Department of Health Care:

Dear Dr LF, Although I am responsible for the complaints in the area of psychiatry, I am not informed about any conception or policy by the Ministry of Health. Currently we are working on health care reform legislation and do not solve any specific issues of individual specialties. Bw. Dr. HS"

On my request whether I could be referred to anyone else who is responsible for this agenda and who could have any information I got a following response:

"It is unlikely that someone in the Ministry of Health would be able to provide you with any further information. I recommend you to contact Czech Psychiatric Society. Professor Jiří Raboch is a member of scientific committee of the Ministry of Health and might have more information."

Professor Raboch did not respond any of my emails either.

I attempted for the last time in 2010 with an enquiry regarding the implementation of the international treaties in the area of mental health care signed by the Czech Republic. I got an automatic response with the number allocated to my email with no further response. Rather curiously two years later I got a notification that my email was deleted by the system.

<sup>188</sup> With two minor exceptions, all recent ministers of health were medical doctors by training, one of them a psychiatrist, Dr. Ivan David (whom I interviewed). My colleague in Public Health department, Dr. David Marx, who used to be advisor to the minister in late 1990s, provided me with additional information.

## Psychiatrists

The world of Czech psychiatry is relatively small – all my informants knew each other, many of them used to be colleagues in one institution or another, and often also collaborated on various projects related to the transformation of care. Many of my informants also served in multiple offices and have represented different institutions – both governmental and non-governmental – and their professional trajectories are illustrative of the wider social networks and interactions between the state (government institutions and parliamentary bodies), NGOs and professional organisations. These interviews were conducted in their offices or in a café, in two cases I was invited to their home.

In addition to hospital psychiatrists I interviewed founders and directors of several NGOs providing community services (Klinika nad Ondřejovem<sup>189</sup>, Eset<sup>190</sup>, Fokus<sup>191</sup>, Bona<sup>192</sup>) – all of them are psychiatrists and active members of the Social Psychiatry Section of Czech Psychiatric Society, and some are also founders or collaborators with the Prague based Center for Mental Health Care Development<sup>193</sup>, institutions that aimed to prepare and implement the proposed transformation.

There were often very tangible tensions and among the psychiatrists who represented different opinions about the role of psychiatry and forms of mental health care. In many interviews I encountered complains and criticism towards their professional colleagues – often bordering with open hostility, rich in psychopathology terminology. Often they expressed accusations and blame for the miserable state of Czech psychiatry, but nevertheless, all of them were very kind and open in sharing their opinions with me. The interviews were semi-structured: I was enquiring about the ways in which they ended up working in psychiatry and mental health care, about their professional experience and how this shaped their personal views on the field, on the ways in which their institutions contribute to both practical and political dimension of their work, and followed their narratives in various directions.

## Government Human Rights Initiatives

My first contact with the government was Dr. Jan Jařab, medical doctor – and UCL trained anthropologist – who was the second appointed Government Commissioner for Human Rights<sup>194</sup> (this post was established in 1998, between 2007-2010 the government also appointed Minister for Human Rights and Minorities

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<sup>189</sup> <http://www.ondrejov.cz/>

<sup>190</sup> <http://www.klinikaeset.cz/>, <http://www.esethelp.cz/>

<sup>191</sup> <http://www.fokus-cr.cz/index.php>, <http://www.fokus-mb.cz/>

<sup>192</sup> <http://www.nadacebona.cz/>, <http://www.bona-ops.cz/>

<sup>193</sup> <http://www.cmhcd.cz/index.php>

<sup>194</sup> <http://www.vlada.cz/cz/pracovni-a-poradni-organy-vlady/zmocnenec-vlady-pro-lidska-prava/cinnost/zmocnenec-15656/>

in parallel). The area of psychiatry was one of his interests and he included the area into the government reports on human rights. In parallel to the post of Commissioner, there is also the Government Council for Human Rights<sup>195</sup> and two of its sections are relevant for psychiatry – the Committee against Torture and Inhuman Treatment, and Committee for Human Rights and Biomedicine. I interviewed two members of these committees (who were also representatives of Czech Psychiatric Society and various NGO's in the same time).

In 1999, the Parliament established the Office of the Public Defender of Rights (Ombudsman)<sup>196</sup>. While in the office, Dr. Otakar Motejl (2000-2010) initiated and conducted audit on human rights in psychiatric hospitals, and issued report of their audit with recommendations for relevant government offices.

### **Non-Governmental Human Rights Initiatives**

Among the NGOs which work in the domain of human rights of psychiatric patients belongs Czech organization League for Human Rights<sup>197</sup> (established in 2002 and a member of the International Federation for Human Rights), and the Budapest-based international Mental Disability Advocacy Center<sup>198</sup> (established in 2002). Both of them are advocacy organization aiming to implementation of human rights agenda in healthcare and in the area of mental health and have slightly 'antipsychiatric' and significantly anti-institutional tone to their activities. These two organisations closely collaborate. I was unable to interview any of their representatives, but some of the psychiatrists I interviewed closely collaborated with them. I also use their various reports and press releases as data.

### **Patient Organisations**

There are several organizations and associations that aim to promote patient's participation and advocate their interests in mental healthcare. In comparison to other patient advocacy groups there is very little initiative directly from patients, and most of the organizations were founded by their 'advocates': psychiatrists, lawyers, and other health care professionals. Their agenda includes patient education, peer-support, medical and legal consultation, as well as psychosocial rehabilitation, and support for family members. Most of these closely collaborate with other organisations and NGOs – day-clinics, protected workshops and sheltered housing projects, as well as various clubs, workshops and cafés aimed at psycho-social rehabilitation, among them *Green Doors*<sup>199</sup> and *Baobab*<sup>200</sup> – and many of the

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<sup>195</sup> <http://www.vlada.cz/cz/pracovni-a-poradni-organy-vlady/rp/rp-uvod-17537/>

<sup>196</sup> <http://www.ochrance.cz/>

<sup>197</sup> <http://www.llp.cz/cz/>

<sup>198</sup> <http://www.mdac.info/>

<sup>199</sup> <http://www.greendoors.cz/>

<sup>200</sup> <http://www.osbaobab.cz/>

professionals I interviewed are active members or even founders of these. Some of these organizations publish their own journals.

Among the associations that were involved in the debate around transformation of psychiatry are the Czech Association for Mental Health (*Česká asociace pro psychické zdraví*<sup>201</sup>), Czech Society for Mental Health (*Česká společnost pro duševní zdraví*<sup>202</sup>); Kolumbus<sup>203</sup> and Sympathea<sup>204</sup>.

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<sup>201</sup> <http://www.capz.cz/>

<sup>202</sup> <http://www.csdz.cz/>

<sup>203</sup> <http://os-kolumbus.org/>

<sup>204</sup> <http://www.sympathea.cz/>

## **APPENDIX 2**

### **TRESPASS, CRIME AND INSANITY: THE SOCIAL LIFE OF CATEGORIES**

*“...Then I went to the school for librarians and publishers in B, and I was as far as in the third year when this fatal episode with my mother happened, when I actually knifed her to death, and then I spend five month in the prison, and afterwards I was transferred – after the prosecution was suspended on the grounds of insanity – I was transferred here to this institution and here I am for a year and a quarter and I am waiting for what is to come...”*

Josef K. 2008

## **Introduction**

Although it might seem that anyone addressing the notions of crime and insanity, treatment and punishment inevitably finds themselves on Foucaultian territory, my aim in this paper is not a dialogue with the work of Michel Foucault (1965, 1977) – whom I consider a historian of a specific culture of classical France. His studies on the logic and technologies of power certainly have wide resonance and have influenced the ways in which we conceptualize and understand the historicity of contemporary practices both in the area of medicine and jurisprudence. However, in this contribution I intend to complement his perspective ‘from above’ with the perspective ‘from within’: my interest in this paper is twofold. First, to understand what it means to interpret specific transgressive acts within specific frameworks – in this case moral, medical, legal and religious. Second, to examine assumptions about the nature of such seemingly transgressive acts that allow people to place them in such general categories. As Hans Georg Gadamer demonstrated, meaning is not a quality of a thing as such but is always derived from its context (1994). In this sense, the interpretative context is constitutive of meaning. I am therefore interested in the law and medicine as a resource for the interpretation of human action and behaviour, and in their normative role in human affairs. These interpretations presuppose as well as constitute the moral dimensions of reality.

This paper will be structured around a case study of a young man whom I shall call Josef K, that I encountered when he was a patient in the forensic ward of a psychiatric hospital. After being found guilty of killing his mother and sentenced to prison, he was later exempted from criminal culpability on the grounds of insanity and transferred to a psychiatric hospital. His act was therefore reclassified – although with a fair amount of uncertainty – from crime to insanity. His family, nevertheless, interpreted the event as unforgivable trespass, as a guilt from which he could never be absolved. He himself was rather unsure about the nature of his act, claiming a lack of clear memory of the actual event, and refused to identify with the act itself. He was rather confused by the multiple possible interpretations and even the very

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<sup>205</sup> In: Ian Harper, Tobias Kelly, Akshay Khanna (Eds.) *The Clinic and the Court: Law, Medicine and Anthropology*. Cambridge University Press 2015

possibility of ‘acting as someone else’, as he retrospectively described the event. These shifts in interpretation left him caught in an abyss of in-between-categories, living in an psychiatric institution for an indeterminate time with a very little hope of resolution and a lack of definite answers.

Drawing on the work of historian Daniela Tinková, namely her book *Crime, Sin and Madness in the Era of Disenchantment of the World* (2004), I will address specific variations on the distinctive categorical registers – moral, medical, legal and religious – that have been used as alternative explanations for the death of the young man’s mother. Addressing the notions of intentionality, responsibility and culpability I will explore the assumptions of these categorical frames with regard to agency, temporality and possibility of resolution. I will also present the current legal and institutional framework for forensic psychiatry and address the ambiguities created by uncertainty that expose the limits of medical and legal expertise with regard to subjectivity of experience. The paper examines Josef’s account of his movement between different registers of expertise and institutional forms – mainly medical and legal – and the ways in which these result in his own sense of alienation from his own acts. Overall, the paper examines the ways in which criminal law and psychiatry draw on one another in order to make the causes of transgression visible – through expert notions of culpability and capacity. Ultimately though law and medicine fail to come together in a neat and clean embrace. On one level Josef’s own family continue to maintain moral interpretations of his act that exceed the clinical or the legal. On another level, Josef is left in a space in-between, a no-man’s land, where both law and medicine are ultimately implicitly forced to admit the inadequacy of their claims to either cure or punish.

### **Josef K.**

Josef was 24 when I met him. He was one of the younger patients on the forensic ward in the Psychiatric Hospital in Kosmonosy. This hospital is located in a small village in North Bohemia and was founded in 1867 on the premises of a former monastery. As the ‘Royal Bohemian Provincial Asylum for Insane’ the hospital offered a refuge for patients with ‘incurable conditions’ who were transferred here from the neuropsychiatric clinic in Prague. By 2013, it took care of 650 in-patients and offers treatment for patients from a substantial region of North Bohemia. In addition to acute psychiatric care, the hospital also provides long term care for patients suffering from chronic forms of psychiatric conditions – patients with dementia, severe forms of mental disability presented alongside mental illness, for patients with sexual deviance, also for patients with forensic history. As a researcher (and, officially, a psychiatry trainee) I was working closely with a young psychologist whose primary responsibility was on the forensic ward. It was here that I encountered Josef regularly on the morning ward meetings, as well as at art therapy, hippotherapy and group therapy sessions. Josef also always greeted me eagerly when I was passing the hospital laundry where he worked during the day. He was respected by other patients since he was quite outspoken, rather friendly and a good natured

man. *"You should not be misled by his behaviour"*, said the psychologist one day. *"He is a very clever man indeed. Do you know why he is here? He killed his mother. Supposedly schizophrenia – have you ever seen such a well compensated schizophrenia? I would think he is more of a psychopath than a schizophrenic."* This doubt about the nature of his condition, presented as a diagnostic dilemma with wide reaching consequences, was a first reminder that diagnostic categories as written on paper are never self-evident, and can always be otherwise.

One day I asked Josef whether he would be willing to talk with me for about an hour, since I was conducting interviews with people suffering from schizophrenia to learn more about their experiences of illness and its treatment. He agreed. The psychologist allowed me to use her room, which was simply but welcomingly decorated, despite being full of old and partially broken furniture, with piles of books and patient documentation on the floor. I was trying to remember the guidance we received as medical students on the spatial order in the room when conducting interview with potentially 'dangerous' patients – you always have to be closer to the door than the patient is, and have your phone ready close by. However, although I was well aware I was quite close to a strong and well built man whose past might cause anxiety, Josef's manners did not directly indicate the need for such precautions. As before, he was friendly and well mannered, and we soon became immersed in a rather unusual conversation. Although in the beginning I roughly followed the open-ended style of medical interview on the experience of illness, I was much more interested in what it was actually like to experience all these things, to have such a history. I was well aware that his account has been edited by being told over and over again to people of various roles – physicians, friends, police, judges, psychologists, other patients. Josef told me about his childhood in a small spa town, early years in school, playing truant and smoking marijuana, of his military service and adventurous trip to London and disappointing return to the grey, small town of Prague, and his subsequent training in technical and librarian school. As he continued his narrative I asked him at which point did the illness appear? I quote his answer below at length.

"Well, officially according to the expert evidence – and that is what I forgot to add before – that in year of 2005 after the symptoms of schizophrenia or psychosis appeared, I was hospitalised in this institution on the A12 ward. I spend there about six or eight weeks and was discharged, with the diagnosis of diminished social adaptability. They did not recognise then that it actually was a schizophrenia, and because of that reassurance I was convinced that I am all right. I ceased to attend to my doctor, and that is why the recurrent relapse came about and that what has happened later in that year of 2006. Then again I heard the voices. It was something like that the neighbours were slandering over me that I only stay in my bed and am not even able to cook my own meals, and more of such flagellant comments on all of my behaviour. And so I went out for a jog and in the park I again heard the voices from the darkness, and here it was a quite cruel persecution already. Then I came back to my family and few days afterwards this happened, I knifed this mum of mine, and... That day, or the evening before that, I went to play football with my



friends. They were all my friends that I knew for long, ever since a primary school days or so, but still I had the feeling that they are all plotting against me, and by means of telepathy soak the energy from me and prevent me from moving and so on. And from the protocol that was brought to me by my lawyer I learned that I behaved strangely and did not respond to their questions and... I behaved in a non-standard way... When I came back home and heard the voices that were attacking me constantly, I realised that... that... simply that I am against all... Additionally, I had a delusion that my father is my teacher together with another man, and I just could not fall asleep in the midst of all this, and as a shield against their attacks I took the book by J.R.R. Tolkien *Hobbit* and when I was reading the words I did not hear the voices but I could not concentrate. I refused to eat the dinner, and finally fell asleep and in the morning I woke up and have heard the voices of all of them, threatening that they tear my brain into pieces, that they steal my memories and lower my intellect, and... well... that was all very intense and... well... I decided to commit suicide and... First I telepathically asked my father to lend me his revolver so that I could shoot myself and my father replied that he no longer trusts me, that I am already too much on their side and he can no longer protect me, that I take over their appearance and behaviour and so I decided to commit suicide with the knife that I took from the kitchen and run out of the house and cut myself four times in my throat in the garden of a café that is very close to us... Because I considered the owner of the café to be against me so this would be kind of my reward to shame him by bleeding out on his garden, so I cut myself four times in my throat but I did not manage to cut strongly enough... Then I tried to spear it in my heart but I also did not succeed, so I returned back home and I did fling at my mother and eventually I knifed her to death. And then my father came and wriggled the knife out of my hands, thrust me down on the floor, fisted on my face and trampled me to the room next door and called the ambulance – I am not sure anymore whether he called the ambulance from there or from the kitchen, and when the ambulance came that informed the police as well so that the police was there too, and after that he simply told me that actually I killed my mother and I said something like that she is strong and would survive it... Then eventually they embarked me into the car and took some urine samples, and took the blood, and then I found myself in the prison cell.”<sup>206</sup>

What was striking in this account was the apparent neutrality of the whole narrative, as if Josef was actually absent from the events he recounts. Most of the time, he was using passive rather than active verbs, and at times it almost seemed like he was telling a story of someone else entirely – rather a matter of fact account, not coloured by any emotional or personal involvement. He would quote the accounts of others, as well as what the experts thought was going on, and refer to the ‘expert’s’ opinion as an evidence of what actually happened – as if there were no ‘inside’ of the experience. He gave an account of being persecuted by the voices,

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<sup>206</sup> The interviews were conducted in Czech. I have endeavored to translate them in such a way as to maintain a sense of the tone of the original dialogue, including some ungrammatical utterances.

under which influence he first tried to kill himself and when that did not work, he killed his mother who happened to be in the way. He mentions also the mythical world of the Hobbit into which he was trying to immerse himself to escape the 'reality' of being attacked by others, although this 'reality' almost absorbed some of the mythical qualities of the novel and possibly transformed his interpretation of the events. The 'absence' or passivity in the face of psychotic experience was a rather common narrative pattern among the patients I interviewed, however, they also often felt deeply touched by what they actually lived through. This did not seem to be the case with Josef and therefore I asked him about that.

"Well, it is kind of... It is that if someone is under the influence of the acute episode of the attack of the illness then he behaves like someone else, he experience like someone else. It is rather that a state in which I am now and that in which I was when I was ill – or actually I am still ill because it is untreatable illness or treatable but not curable – it is like I realize it was me who has done that all, or who experienced it all, but I do not identify with that. ... In my perspective it is all pure madness... Something happened that is impossible to de-happen... I am sorry for that... On the other hand, well, I did not intend to do it, and it just... It is not – it was not my intention... I loved my mother a lot, and that happened what happened is simply a consequence of the illness that I suffer from... And that is also the reason why I am here and not in the prison."

In this part of the narrative we can follow his depiction of illness as a foreign entity that exerts influence over one's behaviour, something that resists any rational explanation and yet takes over and transforms its subject into someone else. The illness is the source of his action in this account. Josef did not identify with his actions, which he considered external to him. He stressed that the act was not intended, which was crucial for the evaluation of his condition: crime or insanity, and mentions two institution that correspond accordingly with the nature of his act – the prison and the hospital. I therefore asked him about how it came about that he was in the hospital, and whether the fact that he was in the hospital to undergo a treatment (rather than in prison to serve his sentence) had any impact on his perspective on the whole situation.

"I remember it was from the stage when I was brought to the prison and the illness was still strong then I... actually... I was rather overwhelmed by the illness so I was not really aware of the consequences of my behaviour. Later when it slowly faded away so first I was full of optimism that in the prison you could actually even study for a degree and that some ten or fifteen years – as various people told me which I incidentally met in the corridor when we went for a walk or so – so they told me that I would be given twelve years possibly, as I am sentenced for the first time. Then I told myself: twelve years, I would be some 35 by then, well, it is still possible to start all over again, and I might even go for two thirds, so after eight years I could get out, and so I was still rather full of optimism, but later on I started thinking, you know, eight years, that is still a rather long time, or I might be given fifteen, or they might reappraise it to second degree, because it was effected in especially cruel way, and by

then I begun to feel rather nervous, and then... Actually when I was still in B I read in a newspaper that 'jabbing medical student was redeemed by insanity' and actually I begun to hope that I might be also given this 'insanity', that it is just impossible that I knifed my mother that I loved he and I did not want to do it, and actually I told this what I experienced to my fellow prisoners that were there with me, and they said to me you are just mad, you are crazy, it could not simply be true, yes, and so I told to myself that there must really be something more to that all than that I would just go and kill my mother..."

As in the previous account, the illness was the active force behind his experience, overwhelming him and clouding any 'reasonable' thoughts and consideration. Then, almost as if waking up from a dream and finding himself in the prison and finally able to realistically assess his situation, he considered the options he might have in this situation. The idea that the whole experience was an experience of madness is brought to him by reading newspaper, and it is not Josef but someone else who suggests that his act – that remained incomprehensible for him – might be a sign of insanity. This possible explanation would have a decisive implication for his future. He seemed to be struggling to make sense of the whole situation, almost like trying to solve a puzzle, where there seemed to be something more in the equation than what you might gather from a mere external observation of events. However, this is the most problematic point of the whole case: at one level the analyst might claim that Josef is the only one who has access to his subjective experience, who can tell the truth or lie about the voices and delusions, and who can make judgment about his intentions. However, Josef still seemed to be rather confused about the whole thing and claimed he could not actually remember the situation. His own access to the experience, or at least the memory of that experience was indirect and uncertain: "Well, the problem is, I do not remember this at all, I have black-out on the situation when I jugged the knife to my mother, and when I caused what I caused, so I just can not recall it. I know I thought my mom is a witch and she sips energy from me and that even the evening before that because she was sleeping there already before that as she did not want to disturb the father in bedroom because she had a cold, so... Well... I might have heard something like she is a witch, you must kill at least her, or something like that, and so I did fling at my mother and actually I knifed her to death. ... I first wanted to kill myself because the voices were telling me I must murder for them, sell drugs, well, prostitute, and such things, so I thought I would be their puppet and they would influence me telepathically from distance this community of the people that were all against me."

At this point he offered a rather plausible explanation: acting under command of the voices. He was referring to voices of the illness that caused him to act in this way, as an external source for his act – as though through the acknowledgment of this other explanation the whole event seems much more intelligible and even 'rational'. The motive of a witch escaped the imaginary world and fused with the real one, although it is possibly a retrospective explanation through which he was trying

to illuminate his confusion and make his act seem a natural response to the peril he experienced. Nevertheless, this explanation still remained a 'guess' as he claimed to be unable to access his actual experience and capture it in words, since he did not have a clear memory of the events. And although throughout most of his narrative he was aware that the voices were 'outside of himself', external to him, at a certain point this distinction collapsed, where the world of possible delusion and that of the reality merged into one:

"Well, I just was so scared of my own life that... in the expert's report it is stated that I attempted to eliminate imaginary peril in my surroundings, so because I was so scared by what was happening well how I tried to cut my throat and pierce my heart, that I came to the kitchen where my mom was lying on the floor, and well she is a witch... And then I recalled the whole conglomerate of people that were against me, and she was a special instance of that peril and so I did fling at my mother and actually I knifed her to death..."

The switch in perspectives allows the killing of Josef's mother to become an intelligible response to the reality of being exposed to horrifying danger. Recognising and acknowledging the possibility of this other reality, however delusional, has far reaching consequences for evaluation of his act. Here again, Josef refers to the expert opinion as a resource for possible interpretation of this event. He presents their explanation as valid, as it confirms the internal logic of his act as a response to his actual experience of danger. It is impossible to tell whether this confusion was a genuine uncertainty on his part, or whether it was intentional strategy to adopt the narrative of psychotic experience in order to justify the inevitability of his act, as the psychologist suggested. The externalization of the illness and the attribution to agency to schizophrenia is important, as it stands for the distinction between what could be classified as pure psychosis and what constitutes psychopathy. Unlike the experience of psychosis, when one is genuinely overwhelmed by their delusional experience, in the case of psychopathic personality disorder the cause is essentially the person as such, which remains the agent of the action.

This distinction between psychosis and psychopathy is of utmost importance for the legal assessment of Josef's act. It is in this crucial dilemma of how to classify this act the questions about the nature and limits of freedom, the tension between reason and passions, and the extent of human responsibility and culpability, resonate. To understand this multiplicity of interpretations and their validity we need to examine the referential frameworks from which they derive their meaning and the assumptions on which they are based.

### **Trespass, Crime and Insanity**

*"Where they treat of Original Sin, they declare that free will, though impaired in its powers and biased, is not however extinguished. I will not dispute about a name, but since they contend that liberty has by no means been extinguished, they certainly*

*understand that the human will has still some power left to choose good. For where death is not, there is at least some portion of life. They themselves remove all ambiguity when they call it impaired and biased. Therefore, if we believe them, Original Sin has weakened us, so that the defect of our will is not pravity but weakness. For if the will were wholly depraved, its health would not only be impaired but lost until it were renewed. The latter, however, is uniformly the doctrine of Scripture. To omit innumerable passages where Paul discourses on the nature of the human race, he does not charge free-will with weakness, but declares all men to be useless, alienated from God, and enslaved to the tyranny of sin; so much so, that he says they are unfit to think a good thought. (Romans 3:12; 2 Corinthians 3:5.) We do not however deny, that a will, though bad, remains in man. For the fall of Adam did not take away the will, but made it a slave where it was free. It is not only prone to sin, but is made subject to sin. Of this subject we shall again speak by and by."*

This is an excerpt from John Calvin's *Antidote to the Sixth Session of the Council of Trent on the Doctrine of Justification* (1547). Calvin was responding to the Catholic Church's reaffirmation of the doctrine of free will in response to the Protestant challenge that emphasized God's grace to be the source of Salvation, and rejected their teaching on predestination. Since the sixteenth century, the dispute between determinism and free will that resonated in this debate has moved from theology to philosophy, and later psychology, and most recently, biology. The transition of this debate between various scholarly disciplines reflects shifts in authoritative 'truth discourses', moving from theological through metaphysical to the scientific. We might also follow these shifts in the categories through which transgressive behaviour is conceptualized. The influential Christian notion of sin has long served as a source for the legal categories of transgression, and while the image of criminal was fused with that of sinner, the notion of responsibility provided a link between moral and penal transgression. Throughout the Middle Ages the sovereign monarch represented a divine deputy responsible for earthly justice and therefore provided the appropriate space in which to deal with acts considered as sinful/criminal. The Christian interiorization of sin, relegated to the individual 'tribunal of conscience' has arguably led to the disappearance of the transcendent category of sin and to a formulation of crime as a trespass of written and clearly formulated earthly law.

In the early modern period crime ceased to be a private issue between the perpetrator and victim as a transgression of divine law, and became an issue of public interest as an expression of the relationship between the subject and authority. As Daniela Tinková argues in her book *Crime, Sin and Madness in the Era of Disenchantment of the World* (2004), the substitution of the Sovereign God and his earthly deputy as a lawgiver by a sovereign state founded through a social contract resulted in the transformation of the concept of trespass of moral code into that of a crime against the society. This gradual shift in transgressive categories also resulted in the conceptual abstraction and generalization of these categories. In the case of homicide, the legal formulation until late 16th century was an 'article against those

who slaughter', whereas later it was listed as 'a murder'. The crime became to be defined legally and devoid of any interpersonal relations and without reference to transcendental values – crime is a civil or social harm rather than a sin. This also greatly transformed what was considered an appropriate response: where sin allows for the possibility of atonement and forgiveness, guilt can be redeemed by expiatory rituals, in the case of crime the appropriate response is punishment or, later, a rehabilitation. There is no such a thing as forgiveness.

Tinková's claim is that the superiority of God in the hierarchy of protected values was in early modern times substituted by the superiority of the state. The protection of societal – rather than divine – values and principles was to be guaranteed by the public authority. This process, sometimes understood as modernization and secularization, shifted the boundaries between religion, the rule of state law and medicine – some acts were decriminalized, some reclassified from the realm of the sacred to that of secular, and some medicalized. This is not to say that the concept of sin was eradicated, but rather that it had to compete with other potentially more powerful ways of understanding transgression. In the movement from sin to crime there was a redrawing the territory of what activities properly belongs to the sphere of religion or private morality, what is regulated by law, and what is interpreted through the lens of medical discourse. This movement has also changed the concepts of crime, insanity and sin – and freedom – themselves, as their context of interpretation was transformed. Crime is now an act committed in full awareness and with an ill intention, and the newly constituted category of madness represents an exemption from this general premise. The pathologization of criminal behaviour has been a slow process surrounded by scientific debates on the influence of reason and passions on human conduct: it has been popularly assumed that strong instincts can sometimes overrule the moral conscience and force the affected individual to commit offense. In this perspective, the perpetrator becomes the victim of their illness. The crucial concept in this regard is the notion of mental capacity, or competence, and it is on this grounds that the exemption of madness from crime – known as insanity defense – has been recognized by significant number of legal systems.

Criminal law attributes different levels of significance to specific mental disorders. According to the criminal law of the Czech Republic, the criminal act is defined as an act dangerous for the society. The criminal act can be committed only by a person older than fifteen years of age who is mentally competent. In the case of the criminal act being committed by a person who is incompetent, criminal responsibility cannot be established: Incapacity is defined as a lack or loss of the ability to recognize and understand the nature of the act which is dangerous to the society, or the loss of control over behaviour as a consequence of mental disorder present at the time of the offense. Authority to speak on the issue of free will has often been entrusted to the medical profession, especially to psychiatry. In practice, in order to make a judgment about the significance of a mental disorder, the court is assisted by the experts in psychiatry and clinical psychology. The suspect is examined by two experts in psychiatry (or sexology) who might be assisted by a

consultant in clinical psychology. The experts seek to establish relative abilities to recognize and control behaviour with respect to a mental disorder and the specific act. Clinicians are also asked for their opinion on the social dangerousness of the offender with respect to the potential protective measures. The final decisions then lies with the court.

Currently, in the Czech Republic, as in many other places, the definition of mental disorder that results either in the loss of capacity of recognition, or in the loss of self-control, or both, is part of both legal and medical categories. However, it is medical categories that are primarily constitutive of the concept of incapacity. The classificatory categories used in forensic psychiatry make a distinction between permanent mental disorders, temporary mental disorders, and invalid (pathological) mental states. The distinction between partial and full incapacity is defined in forensic psychiatry with reference to the ICD–10 categories: full incapacity is related to severe forms of mental illness – schizophrenia, permanent delusional disorders, acute psychotic disorders, schizoaffective disorders, bipolar affective disorder, dementia; post–injury mental states, severe intoxications; severe mental retardation.<sup>207</sup> Partial incapacity is not defined by law, but in practice is understood as a significant diminishment of the recognition or control that occur in less severe forms of mental illness – bipolar disorders, initial stages of dementia, epileptic personality changes; mental states caused by extreme exhaustion and significantly, lighter forms of mental retardation and, significantly, personality disorders. The assumption behind the notion of personality disorder (a category suggested by the psychologist in the case of Josef K as more appropriate than schizophrenia based on the clinical psychological examination) where the behaviour of the patient is at least partially ego-syntonic, also has implications for the legal attribution of culpability. The legal concept of capacity and responsibility thus relies on medical expert categories. Psychiatric classification is therefore essential for the distinction between partial and full incapacity, which has significant consequences for the measures taken to respond to the act – punishment, treatment, or both.

There are three main medical and legal concepts in play in understanding Josef's act: capacity, culpability and dangerousness. Whereas the concept of capacity relates to the ability to understand the nature and consequences of the act and make a judgment based on this understanding, the evaluation of which is within the authority of medicine, the concept of culpability is related to the intentionality of the act and therefore lies within the domain of law. Incapacity can therefore be established on the medical grounds of insanity, while the intentionality of the act corresponds to the legal notions of responsibility and culpability and therefore makes the subject criminally liable. In this way, the legal and the medical are both constitutive for the concept of dangerousness. However, the definition of dangerousness is rather precarious because of the interdisciplinary tension between law and psychiatry as to what the dangerousness refers to – in law this refers to the dangerousness of the *act* whereas psychiatry is supposed to make a judgment on the dangerousness of the *person*. These distinctions presuppose different forms of assessment and additionally

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<sup>207</sup> The World Health Organisation's International Classification of Diseases.

results in very different social responses: treatment, punishment, protective treatment, rehabilitation or social isolation – or their various combinations.

In addition to law and medicine, there is yet another dimension to the evaluation of specific behaviour. There still remains the interpersonal dimension, the potential harm to those who are affected by the act, and their response. In the case of Josef it was not just his mother who suffered the harm, but the whole family was affected by the loss of his mother. I asked him about how this event affected their relationship?

“Presently, I do not have any contact with my family. About a year ago around this time my father sent me three boxes with my clothes, and the shaving razor, and actually, even before that when I was still in prison he sent me a letter to the life insurance company requesting the cancellation of my contract, and in few simple sentences asked me to sign the letter, and ever since I have no contact with him, nor with my brother and sister, or my grandmother, uncle, cousin, or actually with anyone from my family. ... I sent them letters, and attempted to call them – my father indicated the phone numbers of my brother and sister in the protocol, so I have their numbers in my mobile phone, and tried to called them once, and the sister told me I will not talk to you, she was hysterical when she said that, and my brother just cancelled the call. And then my sister sent me a text last year, actually on July 2, when my mum had a birthday because she always remembered her birthday and has always reminded me because she knew I never remembered, well... she simply wrote me that I have caused her so much pain and suffering that she would never accept me again, and that the death of mum is still very painful and that my mum would have had birthday today...”

Josef’s family therefore did not accept the expert interpretation of his act, for them it remained a deed for which there is no excuse and no atonement. For them, an irreversible harm had been done, and it was irrelevant what the relevant authorities acting on behalf of the state made out of that – it was ultimately an act that effaced and erased Josef from their family. We can see here that there are alternative ways to interpret the situation, each interpretation has its own framework of reference and logic of validity. Insanity is an ‘invisible’ condition and it takes medical expertise to make it visible and valid. Subsequently, it also requires a willingness on behalf of those around the diagnosed patient to believe and accept this expert interpretation. The medical diagnosis did not seem a credible explanation for Josef’s family. Josef himself was rather confused about the whole situation and about the nature of illness that might have caused him to act in this way:

“I did not know it is actually the illness, I have never heard of such an illness, none told me the symptoms of the illness, you know, I never had that, that awareness the voices are in my head only, so now when I hear the voice, and it happened on a few occasions here that I have heard voices, I was able to discern that these are indeed voices. So in the case that the voices would come over certain acceptable threshold, it means I would hear them more than 30 seconds once a week, I would report on that, and they would alter the medication, and the therapy, and something would be



done about that... I would inform the doctors that I hear voices or that something strange is happening, that I do not sleep or eat or something like that, that something unusual is going on, because it is never just a change from one moment to the other, it always comes as a complex of curious and strange phenomena that all converge to the final breakout.”

Josef here recurses to the medical explanation of the nature of illness and its symptoms – the voices – that are external to him and should be properly managed by medical means of treatment therapy.

Crucially, the doubts about the nature of Josef’s condition held by the psychologist are important: they draw a distinction even within the category of mental illness. Schizophrenia is more likely to be perceived as something external to the person, treatable if not curable, whereas psychopathy as an inherent trait or almost an essence of a person – not treatable by the standard means of biological psychiatry, but also not something entirely punishable, more appropriately subject to isolation and attempts to rehabilitation and reeducation. This distinction between the external and internal cause is then reflected in the assessment of partial or full incompetence and the level of legal culpability.

The authorities that were to decide on Josef’s fate had the assistance of various forms of clinical and legal expertise. However, these experts provided multiple and sometimes contradictory, evaluations and interpretations: the legal framework first established the act as a crime, and later the psychiatric framework made illness visible as a cause of his behavior. Psychiatrists evaluated the situation as an act committed under the influence of mental condition – a mental illness that was external to Josef K. rather than a deliberate act and intention. However, this judgment was made on the basis of external appearances, while acknowledging the inaccessible interiority of the person. When I asked Josef about his prospect of future, he acknowledged the complexity of making a judgment, and his answer expressed his consignment to the expert opinion:

“... It all depends on the expert’s reports, how they will judge on my health status, and the danger to society and so on, it is not an easy task, what I did is a great trespass, actually the greatest one can do, that even if I caused it, even if my illness caused it, so it would not be an easy judgement to make you know and it all depends on how the situation would evolve...”

### **One Apple can Spoil the Whole Barrel: Punishment, Treatment, and the Protection of Society**

The uncertainty about the validity of either of criminal or clinical interpretations of Josef’s act finds its expression in the variety of institutions and institutional regimes aimed at treating and caring for persons who find themselves

having committed a transgression. The impossibility of drawing a clear line that separates insanity and crime, and the grey zone that occurs where these two intersect, is reflected also in the structure of institutions. It is not a coincidence that prisons and psychiatric hospitals have historically been part of similar project of control. Inmates of both of these institutions share similar state of liminality and social seclusion. However, the concurrent fusion of incapacity and dangerousness does not allow some patients/criminals to fit entirely into either of these institutional categories. In case of Josef, there were multiple transfers between various prisons and a hospital: “They brought me to R [prison] and there I brawled with another man because I borrowed the book that was on his table and so I throttled him and in that moment the warder was there and he told me that simply I am transferred to B and I told him I don’t care, I was there for two days and I did not eat nor drink or I drank but just a little as I thought I am a vampire and suck out the energy telepathically. Eventually, we then went to B [prison hospital], we went by ambulance, with additional police or rather warder escort, and then we arrived to B where I was alone in a kind of admission room where there was only stoneware table, bench, and a bed with iron construction adjusted for restraints, and there I spend eventually a week or maybe ten days in hallucinations and delusions, and then finally they believed me and put me on medication and there I spoke to the doctor and told her my mom was an ill honeycomb that had to be removed and such things, or when she asked me what I am thinking about I told her I plan terrorist attack in Prague underground and so, and then after maybe 10 or 14 days they transferred me to a room where there was a toilet not an Ottoman but a normal one, and where there were these small bedside tables and even the classical hospital bed, and there I was another two or three weeks alone, but in this time I actually read quite a lot and the voices were eventually disappearing, and then actually they put me on a cell with other condemned or accused – no – I must have been with the accused by then. And there in B I was for three month, from November to February, and in February I was transferred again by the escort to P [prison], there I waited for three weeks or maybe a month for the expert verdict and they... they actually decided on the suspension of prosecution and concluded that actually I was insane. And then I was transferred back to R, there I spend three weeks, and then I was transferred here [psychiatric hospital].”

The above account, however confused, gives a sense of the uncertainty about how to judge Josef’s state and condition. It is interesting to follow the differences in the material world of the institutions – in his account of the prison and of the hospital, Josef would often mention details of the interior of the institution – stoneware table, bench and bed with iron construction adjusted for restraints in the prison; the bedside table and hospital bed, and later the ‘home-like feeling’ of the hospital. The minimalistic interior of both of these quite nicely and accurately reflects the reduction of life in the space of institutional order. Similarly, his experience of time was also significantly transformed: the suspension of time in between waiting oriented towards future and his recollection and meditation over the past that were like a key to one of the possible doors: prison, hospital, or yet

something else. I asked Josef about what it was like to live in this suspended state and location outside of the world, and his response vividly contrasts these two spaces outside the one that he inhabited before the fatal event.

“Well... when I was brought here [the psychiatric hospital], I was just like a rapture, this incredible freedom, because I still had a fresh alive memories of the suffering in the prison, where a man was once daily launched to the courtyard to the concrete corridor, where he could spend this one hour, and then he was strike back to the cell, which was about the same size as this room, where he would spend the rest of 23 hours, but even in the prison thanks to that I had a good fellow prisoners – with one exception, he was just an idiot with whom I just could not get around so that they even had to transfer us to different cells – so with the people there I could share what I experienced and we speculated what is going to happen next, what the resolution might be like, and in a way they even helped me materially, they brought me tobacco and such things, because I had no resources, and no contact with the outer world, which helped me to bear even the prison where the lack of freedom was quite extreme relatively well. And then afterward when I was transferred here I thought it is just as on the castle, the cultural room is such a homey room, so I was rather excited about this place, and with the time this euphoria is leaving me and I think that still in comparison to the life I lived before this happened so the lack of freedom, the restriction in rights and freedoms... Well... My perspective on this is that I have done something that you should not do, and even though I was ill the society needs to protect itself, so I would have to spend some time here, so that there is a certainty that the illness is under control, that I am in the remission, that the treatment responds to the symptoms of the illness and endure it here somehow... And so that I have to flog myself to keep in some kind of mental condition, and it is not very easy you see, because the environment here is rather frustrating, when you think about it, because here are cases more serious than I am, maybe not in the consequences, but in the expressions, they are going through what I went through and sometimes the medication does not work and so on, and every morning you look out on the landscape around through the bars in the window, so it affects you, but still it is better than to spend fifteen years somewhere in the prison, or eighteen, so... I manage to bear it so far...”

In his narrative, the impressions of the environment was infused by a reflection of what the different institutional regimes disclose about the nature of the act, be it a crime or illness. He talked about his fellow inmates with whom he shared his fate for now, and on the time perspective that colours his perception of both his future and his past. A criminal sentence is usually given for a specific time period, whereas treatment – especially in conditions deemed untreatable or incurable – lacks the definitiveness of time and becomes waiting for healing that might never come.

However, neither of the two institutions – prison or psychiatric hospital – are currently considered appropriate for people with both a psychiatric and a criminal history. In 2005 the Czech government approved a plan to establish specially secured detention institutions for patients who cannot be convicted because of their

incapacity, and for offenders with severe personality disorder. These detention institutions represent in some way combination of both psychiatric hospitals and prison. The director of the largest psychiatric hospital currently taking care of twelve hundred patients explained:

“Detention institution is an institution where those people should be placed who nowadays are being solved by protective psychiatric or sexological treatment and is aimed for those in whom the treatment can not fulfill its purpose because their disorder is incurable or they refuse the treatment while remaining socially very dangerous. These patients currently cause a lot of trouble to the psychiatric hospitals since they often interfere with therapeutic regime. They often refuse treatment and convey these attitudes on other patients, they create atmosphere that not only lacks being therapeutic, but can be extremely hostile towards all therapeutic attempts, and therefore they prevent treatment of others whose therapy might otherwise be successful. On the other hand, these patients can not be guaranteed adequate therapy in the prisons.”<sup>208</sup>

The emphasis on the therapy of even ‘incurable’ conditions is what makes the regime in such institutions hospital-like. The prison is not considered appropriate for them since it lacks this emphasis on therapy or treatment. Many professionals saw this as a benefit and welcomed the establishment of the detention institution, which would combine psychiatric hospital and prison. The representative of the Ministry of Justice explains the rationale of this decision:

“The judges very often complain that institutions for the execution of punishment are not sufficient for offenders of serious crimes, violent crimes, who were lacking capacity in the moment of their crime. They are given so called institutional corrective education and this institutional corrective education does not fulfill and does not guarantee the basic condition that the offender can not come into contact with society, in other words, that they can escape from these institution and continue with their criminal activities.”<sup>209</sup>

The emphasis here is on re-education, as an addition or substitution of mere punishment imposed of those who committed serious crime. In 2009 a new law that allowed for secluding inmates in a Detention Institution came into force. The director of the first Detention Institution in Brno who is also a consultant in psychiatric ward of the nearby prison hospital, described this first institution and the rules that dictate the live there:

“Detention is aimed for dangerous offenders who committed especially severe offenses, and who committed them under the influence of disorder and protective treatment is not effective or can not provide sufficient protection of the society. In respect to the law they are inmates – neither convicts, nor patients. They are provided

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<sup>208</sup> Czech Radio programme 21.1.2005 following the government’s decision to establish detention institutions, <http://www.radio.cz/cz/rubrika/udalosti/v-cesku-vznikne-detencni-ustav>.

<sup>209</sup> Czech Radio programme 21.1.2005 following the government’s decision to establish detention institutions, <http://www.radio.cz/cz/rubrika/udalosti/v-cesku-vznikne-detencni-ustav>.

health services similar to those in psychiatric hospital, and the building and interiors are more like a prison, we have here warders, cells and security. The security makes it more like a prison, so the risk of escape is minimal. Internal regime however involves treatment and therapy and is therefore more like a healthcare institution. The inmates do not have to wear prison clothes, they can wear their civil clothes – if they have someone who will do the laundry for them – or they can wear institutional clothes from our hospital, i.e. pyjamas. We plan to have community sessions, therapeutic consultations, occupational therapy and workshops, psychotherapeutic group sessions and psychiatric care if required. In comparison to convicts the regime is less strict, the rules regulating the visits, correspondence, packages and walks in the prison space. Detention is aimed for the most dangerous patients, who in addition often boycott the treatment, and therefore the change of their attitude is necessary so that they cooperate, and then their transfer to psychiatric hospital might be considered where they will have less strict regime.”<sup>210</sup>

We can see that this varied and complex mix of punishment and education, care and treatment, isolation and rehabilitation is symptomatic of all these spaces – psychiatric hospital, prison, and detention institution. Each of these institutions shares these characteristics to different degree. With the emergence of detention institutions (where, nevertheless, only people committing a new crime can be transferred from hospitals) this space ‘in-between’ finds its very expression.

How can we understand this space in-between? In-between in the terms of medical and legal categories, in-between in the terms of institutional order, and in-between in the terms of suspended time? Is this third category of ‘detention’ institution a material affirmation of the ambiguity with regard to the status of these people, expression of uncertainty about the nature of their act, the confusing mixture of all these possible facets of their behaviour, character, and fate? Does this creation of a third category represent a space where uncertainty and ambiguity might more comfortably coexist and inhabit the same space, or where these uncertainties can be hidden away? Either way, such spaces are representative of a doubt over the possibility of cure or re-education, and the pitiful inadequacy of punishment.

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<sup>210</sup> Interview for iDNES, 18.3.2009, [http://brno.idnes.cz/detence-lecebna-ani-vezeni-rika-sef-ustavu-fii-/brno-zpravy.aspx?c=A090317\\_200656\\_brno\\_krc](http://brno.idnes.cz/detence-lecebna-ani-vezeni-rika-sef-ustavu-fii-/brno-zpravy.aspx?c=A090317_200656_brno_krc)

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